

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

CHARLES HICKS (AIS# 246241),

*

Plaintiff,

*

v.

CIVIL ACTION: 2:06CV-990-MEF

*

ALABAMA DEPARTMENT OF
CORRECTIONS, et al.

*

Defendants.

*

SPECIAL REPORT OF DEFENDANTS
PRISON HEALTH SERVICES, INC. AND DR. CORBIER

COME NOW Defendants, Prison Health Services (identified in the plaintiff's Complaint as Prison Medical Services) (hereinafter "PHS") and Paul Corbier, M.D., in response to this Honorable Court's order and presents the following Special Report with regard to this matter:

I. INTRODUCTION

The plaintiff/prisoner in this case, Charles Hicks (AIS# 246241), has been incarcerated since April 2006 at various facilities in the State of Alabama. Regarding this particular complaint, Hicks alleges his place of present confinement is the Frank Lee Youth Center, Deatsville, Alabama.

On or about October 19, 2006, Hicks filed a complaint against Defendant PHS and others surrounding the allegedly inadequate medical care received by him as an incarcerated prisoner with the Alabama Department of Corrections. Defendant PHS is a company currently contracting with the Department of Corrections to provide healthcare services to

inmates within the State. Specifically, Hicks claims inadequate medical treatment surrounding diabetic services. Hicks seeks an unknown amount in damages.

Pursuant to this Court's Order, Defendant PHS has undertaken a review of Hicks' claims to more completely understand the facts and circumstances surrounding the complaint. Defendant PHS submits this Special Report supported by a certified copy of plaintiff Hicks' medical records [Exhibit "A"], the Affidavit of Dr. Paul Corbier [Exhibit "B"], and the Affidavit of Darryl Ellis [Exhibit "C"], and other enumerated exhibits. These evidentiary materials, along with the appropriate law, demonstrate that Hicks (1) failed to follow required administrative procedures pursuant to the Prison Litigation Reform Act of 1995, 42 U.S.C. §1999(e), et seq., ("PLRA") and (2) was provided appropriate medical care for his complaints at all times, and that his complaint is due to be dismissed.

II. NARRATIVE SUMMARY OF FACTS

Hicks claims to have been incarcerated with the Alabama Department of Corrections since April 2006. Hicks claims that he has been provided inadequate medical treatment concerning complications from diabetes, specifically in his left leg. In his complaint, Hicks asserts that he has filed "numerous grievances" pertaining to his condition and currently claims to be in constant pain.

Hicks filed a sick call request on August 2, 2006, indicating a need to see a doctor "real bad because I am not feeling well at all." [Exhibit "D"]. Hicks complained of feeling very weak and reported his diabetic condition to the treating nurses. He was instructed to notify PHS physicians if his glucose level was less than 60. Hicks returned to sick call on August 23, 2006, at which time he was provided medication from the prison's stock and was

ordered to return if his condition worsened. [Exhibit "E" – 08/23/06 note]. Hicks also complained again on September 12, 2006, requesting that he get all medications KOP. On physical exam, his blood pressure was reported as 140/90 and he exhibited good range of motion in his left arm. No swelling was noted in either his right or left shoulder, despite complaints from Hicks concerning pain in these areas.

On September 14, 2006, Hicks completed a request for diabetic shoes. On exam, his ankles were noted as being swollen due to poor circulation. As a result of this exam, he was referred to Dr. Corbier. Dr. Corbier's progress notes indicate that on September 22, 2006, Hicks reported for a follow-up sick call. He again complained of pain in his left neck and chills for the past six (6) days. As for his diabetic condition and problems with his feet, Dr. Corbier's notes indicate that Hicks was presently wearing TED hose to treat for this condition. [Exhibit "A"].

On October 2, 2006, Hicks returned for additional treatment of his neck pain. Dr. Corbier noted a previous left posterior cervical lymph node enlargement and provided medication for this condition. Hicks also complained of persistent lower extremity pain associated with walking. Dr. Corbier ordered additional medication as well as a formal request for diabetic shoes.

On October 13, 2006, Hicks returned for follow-up treatment with Dr. Corbier. He expressed concerns about pain in his left leg and again requested special shoes for elephantiasis. Corbier noted Hicks' left leg had marked swelling and bruising and, as a result, Corbier increased his diuretic therapy and again filled out the appropriate forms for diabetic shoes.

On October 25, 2006, Hicks received a venous doplar assessment on both of his legs after that procedure had been requested. At that time, he voiced no complaints about his medical condition, but did state for the first time that he wanted an attorney contacted regarding his legs. Corbier instructed Hicks to return in 10 days to discuss the venous report results.

On November 3, 2006, Hicks returned to discuss the follow-up test results. Hicks was informed that there was no evidence of deep vein thrombosis ("DVT") in his leg, a positive development given his diabetic condition. [Exhibit "A"]. Corbier noted severe chronic swelling with a history of diabetes and hypertension and ordered Hicks to inspect his leg twice daily. [Exhibit "A"]. A cane and support stockings were provided with instructions to Hicks to keep his legs elevated.

All of Mr. Hicks' medical complaints, with specific emphasis on those relating to his diabetic condition, have been evaluated and treated in a timely and appropriate fashion. [Exhibit "A", Exhibit "B"]. Hicks has been seen and evaluated by medical and nursing staff and has even been referred to outside care providers and provided appropriate care when medical conditions may have warranted such a referral, including outside diagnostic testing pertaining to a possible diagnosis of DVT. All of those outside tests were also negative.

Both the Frank Lee Youth Center and Station Correctional have in place a set of grievance procedures specifically related to health complaints. [Exhibit "F"]. It is required that inmates file grievances concerning healthcare services in order to facilitate a prompt review of the medical records. [Id.]. If necessary, the inmate is then interviewed and a review of the grievance occurs within three (3) days after the patient has filed the grievance. [Id.]. If the grievance cannot be resolved to the inmate's satisfaction, the prisoner may

request an appeal in which case his initial written grievance will be reviewed through the facility review process and answered within five (5) days. [Id.]. It is undisputed that Hicks failed to follow the grievance procedures in place prior to filing his complaint in the United States District Court for the Middle District of Alabama.

At all times, the Defendants have exercised the same degree of care, skill, and diligence as other similarly situated healthcare providers would have exercised under the same or similar conditions. [Exhibits "A" – "E"]. In other words, the appropriate standard of care has been adhered to at all times in providing medical care, evaluation, and treatment to this inmate. Id.

At no times have the Defendants denied Mr. Hicks any needed medical treatment, nor have they ever acted with deliberate indifference to any serious medical needs of this prisoner. At all times, Mr. Hicks' medical complaints and conditions have been addressed as promptly as possible under the circumstances.

III. DEFENSES

The Defendants assert the following defenses to the Plaintiff's claims:

1. The Plaintiff/prisoner failed to comply with the mandatory requirements of the Prison Litigation Reform Act of 1995, 42 U.S.C. §1997(e), et seq. ("PLRA") and the PLRA directly applies to require that this matter be dismissed with prejudice for failing to comply with the terms and conditions of grievance procedures concerning medical issues.
2. The Defendants deny each and every material allegation contained in the Plaintiff's Complaint and demand strict proof thereof.
3. The Defendants plead not guilty to the charges in the Plaintiff's Complaint.

4. The Plaintiff's Complaint, as amended, fails to state a claim against the Defendants for which relief can be granted.

5. The Defendants affirmatively deny any and all alleged claims by the Plaintiff.

6. The Plaintiff is not entitled to any relief requested in the Complaint, as amended.

7. The Defendants plead the defense of qualified immunity and avers that the actions taken by the Defendants were reasonable and in good faith with reference to clearly established law at the time of the incidents complained of by the Plaintiff.

8. The Defendants are entitled to qualified immunity and it is clear from the face of the Complaint, as amended, that the Plaintiff has not alleged specific facts indicating that the Defendants have violated any clearly established constitutional right.

9. The Defendants cannot be held liable on the basis of respondeat superior, agency, or vicarious liability theories.

10. The Plaintiff is not entitled to any relief under 42 U.S.C. § 1983.

11. The allegations contained in the Plaintiff's Complaint, as amended, against the Defendants sued in their individual capacities, fails to comply with the heightened specificity requirement of Rule 8 in § 1983 cases against persons sued in their individual capacities. See Oladeinde v. City of Birmingham, 963 F.2d 1481, 1485 (11th Cir. 1992); Arnold v. Board of Educ. Of Escambia County, 880 F.2d 305, 309 (11th Cir. 1989).

12. The Defendants plead all applicable immunities, including, but not limited to qualified, absolute, discretionary function immunity, and state agent immunity.

13. The Defendants aver that they were at all times acting under color of state law and, therefore, they are entitled to substantive immunity under the law of the State of Alabama.

14. The Defendants plead the general issue.

15. This Court lacks subject matter jurisdiction due to the fact that even if the Plaintiff's allegations should be proven, the allegations against the Defendants would amount to mere negligence which is not recognized as a deprivation of the Plaintiff's constitutional rights. See Rogers v. Evans, 792 F.2d 1052 (11th Cir. 1986).

16. The Plaintiff's claims against the Defendants in their official capacities are barred by the Eleventh Amendment to the United States Constitution.

17. Alabama law provides tort and other remedies for the allegations made by the Plaintiff herein and such remedies are constitutionally adequate.

18. The Defendants plead the defense that at all times in treating Plaintiff they exercised the same degree of care, skill, and diligence as other physicians and nursing staff would have exercised under similar circumstances and that at no time did they act toward the Plaintiff with deliberate indifference to a serious medical need.

19. The Defendants plead the affirmative defense that the Plaintiff's Complaint, as amended, fails to contain a detailed specification and factual description of the acts and omissions alleged to render them liable to the Plaintiff as required by § 6-5-551 of the Ala. Code (1993).

20. The Defendants plead the affirmative defenses of contributory negligence and assumption of the risk.

21. The Defendants plead the affirmative defense that Plaintiff's damages, if any, were the result of an independent, efficient, and/or intervening cause.

22. The Defendants plead the affirmative defense that they are not responsible for the policies and procedures of the Alabama Department of Corrections.

23. The Defendants plead the affirmative defense that the Plaintiff has failed to mitigate his own damages.

24. The Defendants plead the affirmative defense that they are not guilty of any conduct which would justify the imposition of punitive damages against it and that any such award would violate the United States Constitution.

25. The Defendants adopt and assert all defenses set forth in the Alabama Medical Liability Act § 6-5-481, et seq., and § 6-5-542, et seq.

26. The Plaintiff has failed to comply with 28 U.S.C. § 1915 with respect to the requirements and limitations inmates must follow in filing in forma pauperis actions in federal court.

27. Pursuant to 28 U.S.C. § 1915 A, this Court is requested to screen and dismiss this case, as soon as possible, either before or after docketing, as this case is frivolous or malicious, fails to state a claim upon which relief may be granted, or seeks money damages from the Defendants who are state officers entitled to immunity as provided for in 42 U.S.C. § 1997 (e)(c).

28. The Defendants assert that the Plaintiff's Complaint, as amended, is frivolous and filed in bad faith solely for the purpose of harassment and intimidation and requests this Court pursuant to 42 U.S.C. § 1988 to award Defendants reasonable attorney's fees and costs incurred in the defense of this case.

29. The Plaintiff's claims are moot because the events which underlie the controversy have been resolved. See Marie v. Nickels, 70 F., Supp. 2d 1252 (D. Kan. 1999).

IV. ARGUMENT

A. Because Inmate Hicks Failed to Follow the Required Grievance Procedures for Assessing Medical Complaints Prior to Filing His Lawsuit, the Prison Litigation Reform Act of 1995 Requires the Immediate Dismissal, with Prejudice, of His Complaint.

With the explosion of prisoner cases becoming epidemic, Congress passed the Prison Litigation Reform Act of 1995 in an effort to control frivolous prisoner litigation. The Act is wide ranging and contains multiple, mandatory provisions that require the dismissal of complaints identical to that asserted by Mr. Hicks.

The PLRA defines a prisoner as follows:

As used in this section, the term “prisoner” means any person incarcerated or detained in any facility who is accused of, convicted of, sentenced for, or adjudicated delinquent for, violations of criminal law or the terms and conditions of parole, probation, pretrial release, or diversionary program. 42 U.S.C. §1997e(h).

Because Hicks admits to being incarcerated in his complaint, he meets the definition of “prisoner” as defined by the PLRA. See Boyd v. Corrections Corporation of America, 380 F.3d 989 (6th Cir. 2004).

The crux of the PLRA requires a prisoner to exhaust all internal, administrative remedies prior to filing suit. The PLRA requires that the Court on its motion or the motion of a defendant dismiss any action with respect to prisoner conditions or medical treatment upon failure to exhaust these remedies. 42 U.S.C. §1997e(a). This provision states the following:

(a) Applicability of Administrative Remedies.

No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted. (emphasis added).

(b) Failure of State to Adopt or Adhere to Administrative Grievance Procedure.

The failure of a State to adopt or adhere to an administrative grievance procedure shall not constitute the basis for an action under 1997a or 1997c of this Title.

(c) Dismissal

The Court shall on its own motion or on the motion of a party dismiss any action brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility if the court is satisfied that the action is frivolous, malicious, fails to state a claim upon which relief can be granted, or seeks monetary relief from a defendant who is immune from such relief.

42 U.S.C. § 1997e(a)

“Administrative remedies” pursuant to this Act constitute prison or jail grievance procedures such as those identified in this Special Report. Before filing suit, the prison/plaintiff must submit his claim through this procedure and the grievance must address the specific issue upon which the suit is based. Failure to strictly follow these procedures requires dismissal of the action. Even if the prisoner/plaintiff has no knowledge regarding the existence of the procedures, this does not relieve the requirement. See Zolicoffer v. Scott, 55 F. Supp. 2d 1372 (N.D. Ga. 1999), affirmed without opinion (252 F.3d 440 (11th Cir. 2001)).

It is undisputed that Hicks failed to follow the appropriate administrative procedures associated with his claim for inadequate medical care. [Exhibit “C” – Affidavit Darryl Ellis]. Because Hicks failed to follow internal procedures concerning these grievances, his claim must be dismissed with prejudice for failing to comply with these mandatory administrative remedies. Woodford v. NGO, 126 S. Ct. 2378, 165 L.Ed.2d 368 (2006).

The Woodford case is extremely instructive because the United States Supreme Court took the opportunity to clarify issues concerning the Prison Litigation Reform Act. In Woodford, a California state prisoner challenged a disciplinary act but did so in an untimely manner, violating California's Prison Grievance System. Subsequently, the prisoner sued the system in federal court, but the district court granted the Department's Motion to Dismiss, stating the prisoner had not fully exhausted his administrative remedies, pursuant to the Prison Litigation Reform Act. On appeal, the Ninth Circuit reversed, claiming that because no administrative remedies remained available to the prisoner, he had "not exhausted them" amongst other reasons.

On appeal, the United States Supreme Court reversed the Ninth Circuit and affirmed the dismissal of the prisoner's complaint. The Court's opinion focused extensively on the "exhaustion" of available remedies and concluded that whether procedural deficiencies existed or whether a prisoner is poorly educated and unfamiliar with such proceedings, it is a requirement that administrative remedies be followed prior to litigation ensuing in federal court. Id. At 2387, 2388, 2390, 2392-2393.

B. The Plaintiff has failed to prove that the Defendants acted with deliberative indifference to any serious medical need.

A court may dismiss a complaint for failure to state a claim if it is clear that no relief could be granted under any set of facts that could be proven consistent with the allegations in the complaint. Romero v. City of Clanton, 220 F. Supp. 2d 1313, 1315 (M.D. Ala., 2002), (citing, Hishon v. King & Spalding, 467 U.S. 69, 73, (1984). "Procedures exist, including Federal Rule of Civil Procedure 7(a), or Rule 12(e), whereby the trial court may "protect the substance of qualified immunity," Shows v. Morgan, 40 F. Supp. 2d 1345, 1358 (M.D. Ala.,

1999). A careful review of Hicks' medical records reveals that he has been given appropriate medical treatment at all times. (See Exhibits "A" & "B"). All of the allegations contained within Hicks' Complaint, as amended, are either inconsistent with his medical records, or are claims for which no relief may be granted. (Id.) Therefore, Hicks' claims against the Defendants are due to be dismissed.

In order to state a cognizable claim under the Eighth Amendment, Hicks must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. See Estelle v. Gamble, 429 U.S. 97, 106 (U.S. 1976); McElligott v. Foley, 182 F.3d 1248, 1254 (11th Cir. 1999); Palermo v. Corr. Med. Servs., 148 F. Supp. 2d 1340, 1342 (S.D. Fla. 2001). In order to prevail, Hicks must allege and prove that he suffered from a serious medical need, that the Defendants were deliberately indifferent to his needs, and that he suffered harm due to deliberate indifference. See Marsh v. Butler County, 268 F.3d 1014, 1058 (11th Cir. 2001) and Palermo, 148 F. Supp. 2d at 1342. "Neither inadvertent failure to provide adequate medical care nor a physician's negligence in diagnosing or treating a medical condition states a valid claim of medical mistreatment under the Eighth Amendment." Id. (citations omitted).

Not every claim by a prisoner that medical treatment has been inadequate states an Eighth Amendment violation. Alleged negligent conduct with regard to inmates' serious medical conditions does not rise to the level of a constitutional violation. Alleged medical malpractice does not become a constitutional violation merely because the alleged victim is a prisoner. See Estelle, 429 U.S. at 106, McElligott, 182 F.3d at 1254, Hill, 40 F.3d 1176, 1186 (11th Cir. 1994), Palermo, 148 F. Supp. 2d at 1342. Further, a mere difference of

opinion between an inmate and the physician as to treatment and diagnosis cannot give rise to a cause of action under the Eighth Amendment. Estelle, 429 U.S. at 106-108.

The Defendants may only be liable if they had knowledge of Hicks' medical condition, Hill, 40 F. 3d at 1191, and acted intentionally or recklessly to deny or delay access to his care, or to interfere with treatment once prescribed. Estelle, 429 U.S. at 104-105. Obviously, Hicks cannot carry his burden. The evidence submitted with this Special Report clearly shows that the Defendants did not act intentionally or recklessly to deny or delay medical care, or to interfere with any treatment which was prescribed or directed. The evidence demonstrates, to the contrary, that appropriate standards of care were followed at all times. (Id.) These facts clearly disprove any claim that the Defendants acted intentionally or recklessly to deny treatment or care.

The Defendants are, further, entitled to qualified immunity from all claims asserted by Hicks in this action. There is no argument that the Defendants were not acting within the scope of their discretionary authority. See Eubanks v. Gerwen, 40 F. 3d 1157, 1160 (11th Cir. 1994); see also Jordan v. Doe, 38 F. 3d 1559, 1566 (11th Cir. 1994). Because the Defendants have demonstrated that they were acting within the scope of their discretionary authority, the burden shifts to Hicks to show that the Defendants violated clearly established law based upon objective standards. Eubanks, 40 F. 3d at 1160. The Eleventh Circuit requires that before the Defendants' actions can be said to have violated clearly established constitutional rights, Hicks must show that the right allegedly violated was clearly established in a fact-specific, particularized sense. Edwards v. Gilbert, 867 F.2d 1271, 1273 (11th Cir. 1989), aff'd in pertinent part, rev'd in part on other grounds, sub nom., Edwards v. Okaloosa County, 5 F. 3d 1431 (11th Cir. 1989).

The Eleventh Circuit further requires that the inquiry be fact specific, and that officials will be immune from suit if the law with respect to their actions was unclear at the time the cause of action arose, or if a reasonable person could have believed that their actions were lawful in light of clearly established law and information possessed by the individual. See Brescher v. Von Stein, 904 F.2d 572, 579 (11th Cir. 1990) (quoting, Anderson v. Creighton, 483 U.S. 635, 640, (U. S. 1987)). The question that must be asked is whether the state of the law in 2006 gave the Defendants fair warning that their alleged treatment of Hicks was unconstitutional. Hope v. Pelzer, 536 U.S. 730, 741 (U.S. 2002).

Therefore, to defeat summary judgment, Hicks must be able to point to cases with “materially similar” facts, within the Eleventh Circuit, that would alert the Defendants to the fact that their practice or policy violates his constitutional rights. See Hansen v. Sodenwagner, 19 F.3d 573, 576 (11th Cir. 1994). In order for qualified immunity to be defeated, preexisting law must “dictate, that is truly compel (not just suggest or allow or raise a question about), the conclusion for every like-situated, reasonable government agent that what the defendant is doing violates federal law in the circumstances.” Lassiter v. Alabama A & M Univ., Bd. of Trustees, 28 F. 3d 1146, 1151 (11th Cir. 1994). The Defendants submit that there is no case law from the United States Supreme Court, the Eleventh Circuit Court of Appeals, or District Courts sitting within the Eleventh Circuit showing that, under the facts of this case, it was clearly established that these alleged actions violated Hicks’ constitutional rights. All of Hicks’ medical needs have been addressed or treated. (See Exhibits “A” & “B”). The Defendants have provided Hicks with appropriate medical care at all times and he has received appropriate nursing care as indicated for treatment of his condition.

V. CONCLUSION

The Plaintiff's Complaint, as amended is due to be dismissed on its face, and is, further, disproven by the evidence now before the Court. All of the Plaintiff's requests for relief are without merit. The Defendants have demonstrated both through substantial evidence and appropriate precedent that there is not any genuine issue of material fact relating to a constitutional violation, and that they are, therefore, entitled to a judgment in their favor as a matter of law. The Plaintiff's submissions clearly fail to meet his required burden.

Accordingly, the Defendants request that this Special Report be treated and denominated as a Motion to Dismiss and/or a Motion for Summary Judgment and that this Honorable Court either dismiss the Plaintiff's Complaint, as amended, with prejudice, or enter a judgment in their favor.

Respectfully submitted,

/s/ PAUL M. JAMES, JR.
Alabama State Bar Number JAM017
Attorney for Defendant Prison Health
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CERTIFICATE OF SERVICE

I hereby certify that a copy of the above and foregoing has been served by U.S. Mail this the 9th day of January, 2007, to:

Charles Hicks (AIS# 246241)
P. O. Box 220410
Deatsville, AL 36022

Greg Biggs, Esq.
Assistant Attorney General
Alabama Department of Corrections
Legal Division
P. O. Box 301501
Montgomery, AL 36130

/s/ PAUL M. JAMES, JR. (JAM017)
Attorney for Defendants Prison Health
Services, Inc. and Dr. Corbier

EXHIBIT A

AFFIDAVIT

STATE OF ALABAMA

COUNTY

I, Tommie Ellerbee, hereby certify and affirm that I am a MEDICAL CLERK, at STATION Healthcare; that I am one of the custodians of medical records at this institution; that the attached documents are true, exact, and correct photocopies of certain medical records maintained here in the institution medical file of one Hicks, Charles, AIS# 246 241; and that I am over the age of twenty-one years and am competent to testify to the aforesaid documents and matters stated therein.

I further certify and affirm that said documents are maintained in the usual and ordinary course of business at _____; and that said documents (and the entries therein) were made at, or reasonably near, the time that by, or from information transmitted by, a person with knowledge of such acts, events, and transactions referred to therein are said to have occurred.

This, I do hereby certify and affirm to on this the 30 day of November, 2006

SWORN TO AND SUBSCRIBED BEFORE ME THIS THE
30 Day of November, 2006

Annie Latrice
Notary Public
12/06/2008
My Commission Expires



PHYSICIANS' ORDERS

NAME:		DIAGNOSIS (If Chg'd)	
D.O.B. / /			
ALLERGIES:			
Use Last	Date	/ /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:		DIAGNOSIS (If Chg'd)	
D.O.B. / /			
ALLERGIES:			
Use Fourth	Date	/ /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:		DIAGNOSIS (If Chg'd)	
D.O.B. / /			
ALLERGIES:			
Use Third	Date	/ /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:		DIAGNOSIS (If Chg'd)	
D.O.B. / /			
ALLERGIES:			
Use Second	Date	/ /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:		DIAGNOSIS	
D.O.B. 11/26/1		246241	
ALLERGIES: MCA		Fyc	
Use First	Date 11/20/06, 1505		<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED

MEDICAL RECORDS COPY



PHYSICIANS' ORDERS

NAME: Hicks, Charles

246241

D.O.B. 11/12/61

FLYC

ALLERGIES: NKDA

Use Last:

Date 120/16/06

NAME: Hicks, Charles

246241

D.O.B. 11/12/61

ALLERGIES: NKDA

Use Fourth

Date 11/7/06

NAME: Hicks, Charles

246241

D.O.B. 11/12/61

ALLERGIES: NKDA

Use Third

Date 11/3/06

NAME: Hicks, Charles

246241

D.O.B. 11/12/61

ALLERGIES: NKDA

Use Second

Date 11/3/06

NAME:

Hicks, Charles

D.O.B. / /

ALLERGIES:

Use First

Date 10/30/06

DIAGNOSIS (If Chg'd)

EC ASA 325mg tpo daily x 100 days

Captopril 10mg tpo daily x 100 days

Metformin 40mg tpo QHS x 100 days

HCTZ 25mg tpo QPM x 100 days

Lisinopril 20mg tpo BID x 100 days

 GENERIC SUBSTITUTION IS NOT PERMITTED

menorrhagia

DIAGNOSIS (If Chg'd)

- T/F Monthly - PCP

- BCG BJD x 100 days

- 2000 AND diabetic diet

- Aldactone 50mg tpo QD x 90 days

 GENERIC SUBSTITUTION IS NOT PERMITTED

DIAGNOSIS (If Chg'd)

1) ASA 81mg PO QD XOP x 100d

2) BBP X 100 days

FLYC

No

quadrant

 GENERIC SUBSTITUTION IS NOT PERMITTED

DIAGNOSIS (If Chg'd)

1) A & D OINT MENT KOP x 90d

2) F/u C/U IN 2-3WKS

3) No prolonged standing, FRONT OF LINE

Parfus < 180 & crme & stockings

Parfus < 180 - venous insufficiency

 GENERIC SUBSTITUTION IS NOT PERMITTED

DIAGNOSIS

HCU F/u T/SF Results - Leg PAIN

disappt 11/3/06

 GENERIC SUBSTITUTION IS NOT PERMITTED



PHYSICIANS' ORDERS

<p>NAME: Hicks, Charles 246241 FLC</p> <p>D.O.B. 11/12/61</p> <p>ALLERGIES: NKDA</p> <p>Use Last Date 10/30/06</p>	<p>DIAGNOSIS (If Chg'd)</p> <p>P Matrin 450 mg BID X 2 days PRN</p> <p>pp. Dr. Corbie / S. Strindberg</p> <p>10:30 AM - 10:30 PM</p> <p><input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED</p>
<p>NAME: Hicks, Charles</p> <p>D.O.B. 11/12/61</p> <p>ALLERGIES: NKDA</p> <p>Use Fourth Date 10/27/06</p>	<p>DIAGNOSIS (If Chg'd)</p> <p>BS BID X 30 days</p> <p>Slide profile → marked peripheral edema</p> <p><input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED</p> <p>RJ C</p>
<p>NAME: Hicks, Charles 246241</p> <p>D.O.B. 11/12/61 FLC</p> <p>ALLERGIES: NKDA</p> <p>Use Third Date 10/26/06</p>	<p>DIAGNOSIS (If Chg'd)</p> <p>(Franklin Nurse)</p> <p>Please inform Pt. of Neg. Venous doppler</p> <p>10:30 AM 3:30 PM</p> <p><input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED</p> <p>RJ C</p>
<p>NAME: Hicks, Charles 246241</p> <p>D.O.B. 11/12/61 FLC</p> <p>ALLERGIES: NKDA</p> <p>Use Second Date 10/25/06 1505</p>	<p>DIAGNOSIS (If Chg'd)</p> <p>Vanish in 10 days re. Neg. Venous</p> <p> Doppler results</p> <p>11/3/06 morth</p> <p><input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED</p> <p>Djiceen</p>
<p>NAME: Hicks, Charles 246241</p> <p>D.O.B. 11/12/61 FLC</p> <p>ALLERGIES: NKDA</p> <p>Use First Date 10/20/06</p>	<p>DIAGNOSIS</p> <p>Blood sugar checks X 2 weeks</p> <p>noted MSander PH 10:30 PM 10/20/06</p> <p><input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED</p> <p>B</p>



PHYSICIANS' ORDERS

NAME: Hicks, Charles 246241 D.O.B. 11/12/61 ALLERGIES: NKDA Use Last Date 10/11/06	DIAGNOSIS (If Chg'd) Lesin 40 mg PO BID x 2 wks 10/13/06 PLYC 10/13/06 <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles 246241 D.O.B. 11/12/61 ALLERGIES: NKDA Use Fourth Date 10/12/06	DIAGNOSIS (If Chg'd) IIM done for Diabetic Shoes 10/13/06 PLYC 10/13/06 <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles 246241 D.O.B. 11/12/61 ALLERGIES: NKDA Use Third Date 10/11/06	DIAGNOSIS (If Chg'd) Schedule HCTU 2 weeks 10/13/06 PLYC 10/13/06 <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles 246241 D.O.B. 11/12/61 ALLERGIES: NKDA Use Second Date 10/12/06	DIAGNOSIS (If Chg'd) 1) Lasix 40 mg PO QAM x 2 wks 2) KCL 10 mg PO QAM x 2 wks 3) PLYC <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles 246241 D.O.B. 11/12/61 ALLERGIES: NKDA Use First Date 10/12/06	DIAGNOSIS ① Procedure day - toenail thing ① 2000 cal ADA diet x 180 days ② PLYC Venous doppler (PVD) ③ Augmentin 875 mg PO BID x 10 days ④ May purchase diabetic shoes off the ⑤ PLYC 12 wks CRNP MDT 10/20/06 <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED



PHYSICIANS' ORDERS

NAME: Hicks, Charles 246241 D.O.B. 11/2/61 ALLERGIES: NKDA		J. Parker, RN 10/10pm 10/10pm	DIAGNOSIS (If Chg'd) ① Please draw DP II ASAP ② Clonidine 0.2mg po x 1now ③ Epsom salt soaks QD x 14 days ④ BP V QD x 14 days
Use Last	Date 10/12/06		<input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <i>Mr. Z. CRNP</i>
NAME: Hicks, Charles 246241 D.O.B. 11/2/61 ALLERGIES: NKDA		9/20/06 1:07p	DIAGNOSIS (If Chg'd) ① DP II ② Bachim DS + po BID x 10days ③ F/U 1m. w/ Mahood, CRNP ④ 1800 cal ADA diet - emerson <i>ZTH. CRNP</i>
Use Fourth	Date 9/22/06		<input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles D.O.B. 11/2/61 ALLERGIES: NKDA		9/20/06	DIAGNOSIS (If Chg'd) <i>Keep scheduled appt 9/22/06</i>
Use Third	Date 9/20/06		<input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <i>BB</i>
NAME: Hicks, Charles D.O.B. 11/2/61 ALLERGIES: NKDA		9/15/06	DIAGNOSIS (If Chg'd) <i>Schedule for HCU next week</i> <i>asap - almost 9/18</i>
Use Second	Date 9/15/06		<input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <i>BB</i>
NAME: Hicks Charles 246241 D.O.B. 11/2/61 ALLERGIES: NKDA		FUC Bm	DIAGNOSIS <i>DiC Maxide</i> <i>HCZ 25mg + po QD x 90 days</i> <i>lisinopril 20mg + po BID x 90 days</i> <i>BP V QD x 14 days.</i> <i>No Kop + Bp Meds till further notice.</i>
Use First	Date 9/12/06		<input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <i>BB</i> <i>dated 9/12/06</i> <i>9/13/06 @ 940p</i>



PHYSICIANS' ORDERS

NAME: Hicks, Charles	DIAGNOSIS (If Chg'd)
D.O.B. 11/02/61	Diabetes MD if glucose less than 100.
ALLERGIES: NKA	<input checked="" type="checkbox"/> Fasting DR X 7 next lab draw
Use Last Date 08/03/06 08/03/06	<input checked="" type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED B1M and CPTP
NAME: Hicks, Charles	DIAGNOSIS (If Chg'd) noted S. Taylor 07/26/06 D/DM, 2000 cal ADA-365
D.O.B. 11/2/61	<input checked="" type="checkbox"/> Coll pt to pull all hair to get pain skin to skin on ADA diet list
ALLERGIES: NKA	<input checked="" type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
Use Fourth Date 7/12/06	<input checked="" type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles	DIAGNOSIS (If Chg'd) HbA1c- change goal to 7% in 3 mos of 7/12/06
D.O.B. 11/02/61	<input checked="" type="checkbox"/> HbA1c on next wed. 07/13/06 + self Dr Pleasant for nail clipping
ALLERGIES: NKA	<input checked="" type="checkbox"/> Check urine microalbumin in 80 days
Use Third Date 07/05/06	<input checked="" type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles	DIAGNOSIS (If Chg'd) Discontinue Vazotec.
D.O.B. 11/2/61	<input checked="" type="checkbox"/> Fluconazole 200 mg po. (D) X 180 days
ALLERGIES: NKA	<input checked="" type="checkbox"/> Fasting profile in 80 days
Use Second Date 7/05/06	<input checked="" type="checkbox"/> Glucose (BS) check. BiD X 30 days
NAME: Hicks, Charles	<input checked="" type="checkbox"/> Extra Lg thigh high 7el ring
246241 5/31/06 0858	<input checked="" type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
D.O.B. 11/02/61	DIAGNOSIS
ALLERGIES: NKA	1) Vazotec 5 mg po qd X 180d
Use First Date 5/31/06	2) Hgb A.C ~ 16 wks

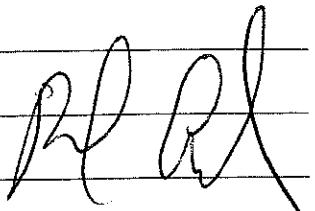


PHYSICIANS' ORDERS

NAME: Hicks, Charles	D.O.B. 11/12/61	ALLERGIES: NKA	Use Last Date 5/19/06	DIAGNOSIS (If Chg'd) Trim Nails to time - notify provider to do ✓ <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles	D.O.B. 11/12/61	ALLERGIES: NKA	Use Fourth Date 5/19/06	DIAGNOSIS (If Chg'd) CC 4 weeks Dm/HIN Lisinopril 10 mg Mayzide 25/50 mg poqd x 180 days ✓ BBP x 3 months ✓ Extra blanket to allow inmate to sleep better <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles	D.O.B. 11/12/61	ALLERGIES: NKA	Use Third Date 5/19/06	DIAGNOSIS (If Chg'd) ECPSA 325 mg poqd x 180 days ✓ Glysetrol 10 mg poqd x 180 days ✓ Lisinopril 5 mg poqd x 180 days ✓ AFC BID x 30 days AAA Thin Layer AID oint AAA BID x 30 days ✓ <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles	D.O.B. 11/12/61	ALLERGIES: NKA	Use Second Date 5/19/06	DIAGNOSIS (If Chg'd) BIS ✓ 5 2x day x 300 ✓ Obtain records from Coopers Green RE Cardiac & DM Lisinopril 2.5 mg poqd x 180 days ✓ mevacor 20 mg poqd x 180 days ✓ <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles	D.O.B. 11/12/61	ALLERGIES: NKA	Use First Date 5/19/06	DIAGNOSIS Cryp, Cho, HgbA1c, TSH, (elev) 140225 EKG, CXR Eye Clinic referral ✓ 2200 calorie diabetic diet & snack ✓ B1/PV 2xwk x 4 wks ✓ <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED



PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
	Hicks Charlie BM246241	11/1/61
11/7/06 823	20th fl. Eral see 11/6/06 sickcall T-980 P-70 B-20 22sat 98.1 B/P 162/102 OKay	WT 280
11/7/06	Pt. Venous doppler () for DVT. Please	
	<ul style="list-style-type: none"> ① Elevated the legs frequent ② Continue using support stockings. ③ Cont. () No prolonged standing prefer 	
	H. B. Pt. () diabetes discussed Diabetes diet 	

Date/Time	Inmate's Name:	Hicks, Charles 24624	D.O.B.:	11/12/61
10:25 AM	Return from FWA Venous Doppler			
3:00 pm	3:00 pm on leg - T 97.8, O2sat 97% P 66, R 20 B/P 156/88			S. Taylor (RN)
	Patient Back from FWA app't re: venous Doppler			
	Study of leg. Q complains vicid			
	PT want attorney contacted re: his leg. Instructed			
	PT have attorney review records for his review,			
	will try back to DC in 10 days for venous			
	report results. PT w/o return paperwork.			
				Noncompliant
11:30 AM	Dot/CP re: flu test result wt 263 T 97.8 P 64			
9:45 AM	R-20 O2sat 99% 146/88			OB
	PT informed results of Doppler study - No			
	evidence of DVT Q. & P A done.			
	4/0 pain along lateral leg.			
	Severe chronic swelling. Hx DM HTN.			
	PT informed to inspect leg twice daily.			
	CANE & support stockings given today.			
	Resume ASA qd.			
				6:00 AM
				LARGE leg: T severe chronic venous insuff
				skin hyperpig & dry - No evidence
				of infect. Fungal nails
A:	<u>DR. H</u>			
				CHRONIC VENOUS INSUFF.
	PT elevated leg profiles given CANE			
	skin care education, A&D ointment			
	Flu shot in 2-3 wks			Dr. corne
				Highly



PROGRESS NOTES

Date/Time	Inmate's Name	D.O.B.:
	Hicks Charles 246241	11/2/61
7-5-06	WT 252 T 98° P 64 R 20 B/P 140/90 O2 SAT 97%	
7-12-06	207bP ii. nail clipping WT 258 T- 98° P- 72 R-20 O2 sat 98% B/P 164/96 Difuse C/o fever, runny nose of foreheads. C. Upper respiratory tract infection.	
9-22-06 8:25 AM	204bP ii. Eval 1/2 neck pain, V3/pst B/S WT 271 BS- 167 T- 98° P- 72 R- 20 O2 sat 97% B/P 128/88 S: Pt. here for flu sick call. C/o "knot on ② side of neck" x 6 days. Pain is ② side temp of neck. Approx 6 days ago c/o chills, fever x 2 days is result of "knot & tenderness" on ① side of neck. Denies cough, nasal drainage, ear pain / drainage, SOB. O: VSS Afebrile. GEN: AAOX3, in NAD. HEENT: Head normocephalic, atraumatic. Eyes: PERRLA, EOMs intact. Ears: TMs intact, no drainage. Nose: Naso patent, no drainage. Neck: ② lymph node enlargement / tenderness, 1cm x 1cm ② posterior cervical. Movable. ② warmth. ② JVD. ② carotid bruits. Throat: Pharynx pink. ② PND. Lungs: CTAK COPD: RRR on/cr/2/c. Abd: Soft, NT, ② BSx, ② HSM. Ext: ② DR/PT pulses. ② generalized, ② LE edema. Presently wearing TED hose.	
P:	1) Posterior cervical enlarged lymph node a) Possible lymphangitis vs. folliculitis 2) Bactrim DS + po B10V 10 days 3) 1 wk. F/Vg. See Box 18 Before Using Another Shee	



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Charles Hicks

ID # 246241

Date of Request: 11-16-06

Date of Birth: 11-2-61 Location: 3#12

Nature of problem or request: I do I need to talk to Dr.

Corbin because my leg is really hurting me real bad.
The fluid in my leg looks like it has gone up my leg
and I don't like that at all.

Charles Hicks

Signature

DO NOT WRITE BELOW THIS LINE

Date: 11/16/06

Time: 11:29 AM

Allergies: _____

RECEIVED

Date:

Time:

Receiving Nurse Initials: SC

(S)ubjective:

11/16/06
11/16/06
11/16/06

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Facility: Alabama Department of Corrections

Patient Name:

Nicks, Charles

Inmate Number:

24624

Date of Report:

11 11 06

First

Date of Birth:

11 12 16 / MI

MM

DD

YYYY

Time Seen:

12:30

AM / PM

Circle One

Subjective: Chief Complaint(s):

Diabetic shoe - need something for pain, leg hurts on

Onset:

Brief History:

(Continuation back if necessary)

Have pain and swelling in left leg for a long time.

 Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.6 P: 84 RR: 20 B/P: 140 / 92

Examination Findings:

(Continue on back if necessary)

Swelling noted left leg. Requesting to see Dr. Carries to discuss outside appt. And need something for pain.

 Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):

 Referral NOT REQUIRED Referral REQUIRED due to the following: (Check all that apply) Recurrent Complaint (More than 2 visits for the same complaint) Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

 Instructions to return if condition worsens. Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits) Other: _____

(Describe)

OTC Medications given NO YES (If Yes List): _____Referral: NO YES (If Yes, Whom/Where): _____

Date for referral: / /

MM DD MM

Referral Type: Routine Urgent Emergent (if emergent who was contacted): MD review

Time _____

x I. Sundale Jr. Name: T. Sundale Jr.
Nurses Signature Printed



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Charles Hicks

ID # 246241

Date of Request: 11-7-06

Date of Birth: 11-2-61 Location: 3D-B #12

Nature of problem or request: I need to go to another free world
Doctor to have a test on my Left Leg again. This
is to Doctor Corbier.

Charles Hicks

Signature

DO NOT WRITE BELOW THIS LINE

Date: 11/7/06

Time: 2050 AM PM

Allergies: _____

(S)ubjective:

RECEIVED

Date: 11/7/06

Time: 2050

Receiving Nurse Initials MH

(O)bjective

(V/S): T:

P:

R:

BP:

WT:

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Hicks, CharlesInmate Number: 246291First Date of Birth: 11, 2, 61Date of Report: 11, 6, 06Time Seen: 12 N AM / PM Circle One

MM DD YYYY

Subjective: Chief Complaint(s): Need to start BS again and leg hurts
real bad. Request to see PA doctor @ UAB or Jackson
 Onset: Onset:

Brief History: Chronic leg pain and edema. Requesting
PA. Also want blood sugar checks.

Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97⁴ P: 80 RR: 20 B/P: 120, 78

Examination Findings: Left leg edematous, C/O real bad pain
and wants PA.

Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):

Referral NOT REQUIRED

Referral REQUIRED due to the following: (Check all that apply)

Recurrent Complaint (More than 2 visits for the same complaint)

Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

Instructions to return if condition worsens.

Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other: _____

(Describe)

OTC Medications given NO YES (If Yes List): _____

Referral: NO YES (If Yes, WhomWhere): MD review

Date for referral: 1/1

MM DD YYYY

Referral Type: Routine Urgent Emergent (if emergent who was contacted?) _____

Time _____

x T. Swindle Jr Name: T. Swindle Jr



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: charLes Hicks

ID # 246241

Date of Request: 11-5-06

Date of Birth: 11-2-61 Location: 3Dorm 1 Bed #12

Nature of problem or request: I need to get start back checking my blood sugar. I also need to talk to Dr. Corbier again about seeing a free world Doctor again. my leg hurts me real real bad. I want to go to UAB or Jackson Hospital for test on my leg and body please.

charLes Hicks

Signature

DO NOT WRITE BELOW THIS LINE

Date: 11/5/06

Time: 8:53pm AM PM

Allergies: None

RECEIVED

Date: 11/5/06

Time: 8:53pm

Receiving Nurse Initials MF

(S)ubjective:

HL UOP 1/6/06

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 10-28-06

ID # 246241 Date of Birth: 11-02-61 Location: 3-#12

Nature of problem or request: I need to see the Doctor because my left leg still hurts me. Also, I need a profile so I can show it to Sgt. Givens.

Charles Hicks
Signature

DO NOT WRITE BELOW THIS LINE

Date: 1/1/

Time: AM PM

Allergies:

(S)ubjective:

*SC
SC, DP
C
MU30, DD
10/12*

RECEIVED

Date: _____

Time: _____

Receiving Nurse Initials: _____

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

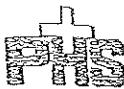
If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Nicks, CharlesInmate Number: 246247First Date of Birth: 11 12 161Date of Report: 10 13 06Time Seen: 12:00 AM / PM Circle One

Subjective: Chief Complaint(s): Need to see eye doctor, request to see another doctor about leg. During a lot of leg pain.
 Onset: Onset

Brief History: Having problem w/ left leg. Pain + swelling
 (Continue on back if necessary)

Check here for additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.6 P: 70 RR: 18 B/P: 110 / 76

Examination Findings: Left
 (Continue on back if necessary)

Check here for additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):

Referral NOT REQUIRED

Referral REQUIRED due to the following: (Check all that apply)
 Recurrent Complaint (More than 2 visits for the same complaint)
 Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

Instructions to return if condition worsens.
 Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)
 Other:

(Describe)

OTC Medications given NO YES (If Yes List): Motrin 400 mg B.i.d x 2 days

Referral: NO YES (If Yes, Whom/Where):

Date for referral: 1 / 1 / 1

Referral Type: Routine Urgent Emergent (If emergent who was contacted?)

Time: 10:00 AM

I. Burnell, RN

10/13/06

Nursing Evaluation Tool:

General Sick Call

Facility: Staton Correctional Facility			
Patient Name: <u>Dicks, Charles</u>			
Inmate Number: <u>246241</u>	First	Date of Birth: <u>11 12 161</u>	
	MM	DD	YYYY
Date of Report: <u>10 12 06</u>	Time Seen: <u>11:55</u>	AM / PM	Circle One
MM	DD	YYYY	

Subjective: Chief Complaint(s): Left leg pain & left leg swelling due to my feet & leg swelling
 Onset: Chronic
 Brief History: Chronic foot & leg swelling
 (Continue on back if necessary)

Objective: Vital Signs: (As Indicated) T: 97.6 P: 68 RR: 20 B/P: 110 / 70
 Check Here if additional notes on back

Examination Findings: Chronic leg swelling left leg
 (Continue on back if necessary)

Assessment: (Referral Status) Referral NOT REQUIRED Preliminary Determination(s): _____
 Check Here if additional notes on back

Referral REQUIRED due to the following: (Check all that apply)

Recurrent Complaint (More than 2 visits for the same complaint)

Other: _____

*Noted
10/21/06*

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

- Instructions to return if condition worsens.
- Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)
- Other: _____

(Describe)

OTC Medications given NO YES (If Yes List): _____

Referral: NO YES (If Yes, Whom/Where): AD review

Date for referral: 1 / 1
 MM DD YYYY
 Time _____

Referral Type: Routine Urgent Emergent (If emergent who was contacted): _____

x T. Swindell
 Nurses Signature

Name: T. Swindell



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Charles Hicks
ID # 246241

Date of Request: 10/21/06

Date of Birth: 11-2-61 Location: 3-#12

Nature of problem or request: I need the doctor to write me some papers so the people here at Frank Lee know that I have permission to wear these slides because my left leg is hurting me real bad.

Charles Hicks
Signature

DO NOT WRITE BELOW THIS LINE

Date: 1/1
Time: AM PM
Allergies:

RECEIVED	
Date:	
Time:	
Receiving Nurse Initials <u> </u>	

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 10/19/06
 ID # 296241 Date of Birth: 11-2-61 Location: 3-42
 Nature of problem or request: I need to have my diabetic
Blood sugar checked every morning
because it is very important.

Charles Hicks
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

RECEIVED
 Date: _____
 Time: _____
 Receiving Nurse Initials

(S)ubjective:

*SC
11/10/06
AM/PM
2000
11/10/06*

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()
 Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

General Sick Call

Facility: Staton Correctional Facility
 Patient Name: Hicks, Charles
 Inmate Number: 246247 Last
 Date of Report: 10/20/06 MM DD YYYY

First Date of Birth: 11/12/10 MM DD YYYY
 Time Seen: 1145 AM / PM Circle One

Subjective: Chief Complaint(s): Want B/S done @ AM
 Onset: years ago

Brief History: Diabetic x's some time and want b/s
(Continue on back if necessary)

Objective: Vital Signs: (As Indicated) T: 97.6 P: 72 RR: 20 B/P: 140, 90

Examination Findings: No acute distress, static no problems
(Continue on back if necessary)
just want B/S @ d

Assessment: (Referral Status)

Referral NOT REQUIRED

Preliminary Determination(s): _____

Check here if additional notes on back

Referral REQUIRED due to the following: (Check all that apply)

Recurrent Complaint (More than 2 visits for the same complaint)

Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

Instructions to return if condition worsens.

Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other: _____

(Describe)

OTC Medications given NO YES (If Yes List): _____

Referral: NO YES (If Yes, Whom/Where): _____

Date for referral: 1/1
MM DD YYYY

Referral Type: Routine Urgent Emergent (if emergent who was contacted): MD review

J. Swindell Jr.
x Nurses Signature

Name: J. Swindell Jr.
Printed



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Charles Hicks Date of Request: 10-16-06
 ID # 246241 Date of Birth: 11-2-61 Location: 3-#12

Nature of problem or request: I am requiring about the orthopedic shoes that i suppose it gets. Dr. Corbin told me that he will let me know when or were will, I go to the hospital to see about my leg. The reason why my leg really hurts me real bad.

Charles Hicks
Signature

DO NOT WRITE BELOW THIS LINE

Date: 10/16/06
 Time: 9:04 AM AM PM
 Allergies:

RECEIVED

Date: _____
 Time: _____
 Receiving Nurse Initials: _____

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Charles Weeks Date of Request: 10-16-06
 ID # 24691 Date of Birth: 11-2-61 Location: 3-12
 Nature of problem or request: I am running about the other cells
show that I suppose it onto the Corridor told me that
he will let me know when or were will I go to the
Hospital to see about my leg the reason why my leg really
hurts and it last Charles Weeks
 Signature

DO NOT WRITE BELOW THIS LINE

Date: 10/16/06
 Time: 4:45 AM PM
 Allergies: _____

RECEIVED

Date: _____
 Time: _____
 Receiving Nurse Initials: _____

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()
 Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name Charles Hicks Date of Request: 10/10/06
 ID # 246241 Date of Birth: 11-2-61 Location: 3 D 2nd Bed #12
 Nature of problem or request: I still require about my orthopedics
shoes and to get my blood pressure checked. I also
need to know how much ~~medicine~~ medicine do I take
everyday please. I want to know about every pill and what it is all about.
Charles Hicks
 Signature

DO NOT WRITE BELOW THIS LINE

Date: 10/10/06

Time: 11:55 AM

Allergies: None

(S)ubjective: None

RECEIVED	
Date:	
Time:	
Receiving Nurse Initials <u>MM</u>	

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 10/10/06
 ID # 246241 Date of Birth: 11-2-61 Location: 3 Dizon Rd b12
 Nature of problem or request: I still requiring about my orthopedic
 shoes and to get my blood pressure checked. I also
 need to know how much ~~medicine~~ medicine I take
 everyday please. I want to know about every pill and what it is all about.

Charles Hicks

Signature

DO NOT WRITE BELOW THIS LINE

Date: / /

Time: AM PM

Allergies:

RECEIVED

Date:

Time:

Receiving Nurse Initials

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Hicks, CharlesInmate Number: 246241First Date of Birth: 11 12 1961Date of Report: 10/11/06Time Seen: 1155 AM / PM Circle One

Subjective: Chief Complaint(s): Need B/P checked and what he find out
 Onset: without shoes, take & far what want to know

Brief History: Diabetic requesting diabetic shoes, diabetic
 (Continue on back if necessary)
8 years

Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.6 P: 80 RR: 20 B/P: 120/86

Examination Findings: Requesting diabetic shoes and wants to know about meds.
 (Continue on back if necessary)

Check Here if additional notes on back

Assessment: (Referral Status)

Preliminary Determination(s):

Referral NOT REQUIRED

Referral REQUIRED due to the following: (Check all that apply)

Recurrent Complaint (More than 2 visits for the same complaint)

Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

Instructions to return if condition worsens.

Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other: _____

(Describe) _____

OTC Medications given NO YES (If Yes List):

Referral: NO YES (If Yes, Whom/Where): MD Review

Date for referral: 1/1/07

Referral Type: Routine Urgent Emergent (If emergent who was contacted?)

Time: _____

J. Swindell LPR

Name: T. Swindell



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Charles Hicks Date of Request: 9/26/06
 ID # 246241 Date of Birth: 11-2-61 Location: 2D - Bed #20
 Nature of problem or request: I need some diabetic orthopedic
shoes real bad and also some Elson sox and
a foot tub for my feet because i have swelling in
left leg that hurts real bad.

Charles Hicks

Signature

DO NOT WRITE BELOW THIS LINE

Date: 1/1
 Time: AM PM
 Allergies:

RECEIVED
 Date: 9/26/06
 Time: 9:20
 Receiving Nurse Initials AN

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

*S/C 12:38
9/27/06
NB*

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()
 Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: HicksCharlesInmate Number: 246241 LastFirst 11 Date of Birth: 12 16 61
MM DD YYYYDate of Report: 9 12 06
MM DD YYYYTime Seen: 12:30 AM PM Circle OneSubjective: Chief Complaint(s): request foot socksOnset: 1982

Brief History:

(Continue on back if necessary)

 Check Here if additional notes on backObjective: Vital Signs: (As Indicated) T: 98 P: 72 RR: 14 B/P: 140 / 78Examination Findings: Pitting edema to D foot + D leg, tender on feet
(Continue on back if necessary)
dark + deformed diabetic, lungs clear + denies
cough Check Here if additional notes on back

Assessment: (Referral Status)

Preliminary Determination(s):

 Referral NOT REQUIRED Referral REQUIRED due to the following: (Check all that apply) Recurrent Complaint (More than 2 visits for the same complaint) Other: Has appt c MD on 9-29-06

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

 Instructions to return if condition worsens. Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits) Other:

(Describe)

OTC Medications given NO YES (If Yes List):Referral: NO YES (If Yes, Whom/Where):Date for referral: 1 / 1 / 06Referral Type: Routine Urgent Emergent (if emergent who was contacted?)Time —x HB 1/06Name: Al Randa, T



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 9/20/06
 ID # 246241 Date of Birth: 11-2-61 Location: 2D-B20
 Nature of problem or request: my neck is hurting me on
my left side real bad. Also, I want to know
about my ~~old~~ diabetes shoes that i ask about
before?

Charles Hicks

Signature

DO NOT WRITE BELOW THIS LINE

Date: 9/18/06

Time: 10:16 pm AM PM

Allergies: _____

RECEIVED

Date: 9/18/06

Time: 10:16 pm

Receiving Nurse Initials HP

(S)ubjective:

(O)bjective

9/19/06
AB
G/C
1:35 pm

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE EMERGENCY

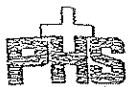
If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name:

Hicks

Charles

Inmate Number:

246241

Last
First
Date of Birth: 11 12 161
MM DD YYYY

Date of Report:

9 19 06
MM DD YYYY

Time Seen: 1:35 AM/PM Circle One

Subjective: Chief Complaint(s): Neck is hurting since Sunday. I noticed
Onset: a Knot on the lt side of my neck.

Brief History: My dad had a Knot at the same place and the
(Continue on back if necessary)

Doctors did surgery and took it out at UAB.

(Dearer injury.) Since I got the Knot I've felt a
little Weakness.

Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 99.8 P: 96 RR: 12 B/P: 142/82

Examination Findings: On exam, large 1/2 golf ball sized Knot palpated
(Continue on back if necessary)
on lt side of neck. Knot Hard. No inflammation, no
pus observed. Tender to touch.

Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):

Referral NOT REQUIRED

Referral REQUIRED due to the following: (Check all that apply)

Recurrent Complaint (More than 2 visits for the same complaint)

Other: Knot on lt side of neck

Has Appt *1/13/06*

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

Instructions to return if condition worsens.

Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other:

(Describe)

OTC Medications given NO YES (If Yes List):

Referral: NO YES (If Yes, Whom/Where): *MD*

Date for referral: *1/1/06*

Referral Type: Routine Urgent Emergent (If emergent who was contacted?)

Time: *1:35 PM*

X

Don Blackmon

Name:

A. Blackmon, RA



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 9/14/06
 ID # 246241 Date of Birth: 11-2-61 Location: 2#20
 Nature of problem, or request: I need some d'Abates shoes
because it important for me to wear them.

Charles Hicks
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

RECEIVED
 Date: 9/14/06
 Time: 8:30 pm
 Receiving Nurse Initials bj

(S)ubjective:

(O)bjective

(A)ssessment:

*4/c
9/15/06
OBM
12.05 pm*

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No
 Was MD/PA on call notified: Yes No

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: HicksCharlesInmate Number: 246241

Last

First

11/12/61

MM

DD

YYYY

Date of Report: 91/15/06Time Seen: 12:05

AM/PM

Circle One

Subjective: Chief Complaint(s): I need some Diabetic Shoes. My shoes have no support. My feet hurt bad. My tennis shoes are very flat and have no arches. Seems like my ankles are getting larger.

Objective: Vital Signs: (As Indicated) T: 98.7 P: 72 RR: 12 B/P: 162/92

ON SP V 1/2 x 14 days

Check Here if additional notes on back

Examination Findings: Very large BM wears tennis-shoes. ankles swollen greatly from poor circulation. Toenail of feet extremely thick and dark, deformed. Needs no nails cut badly.

Assessment: (Referral Status) Preliminary Determination(s): Check Here if additional notes on back

Referral NOT REQUIRED

Referral REQUIRED due to the following: (Check all that apply)

Recurrent Complaint (More than 2 visits for the same complaint)

Other: MD - Extremely Bad Toenails - Diabetic

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

Instructions to return if condition worsens.

Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other:

(Describe)

OTC Medications given NO YES (If Yes List):

Referral: NO YES (If Yes, Whom/Where): MD

Date for referral: 1/1

MM DD YYYY

Time

Referral Type: Routine Urgent Emergent (if emergent who was contacted?)

Amie L. Clark, RN Name: A. Black, RN

Nurses Signature



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name Charles Hicks
ID # 246241

Date of Request: 9-11-06

Date of Birth: 11-2-61 Location: 2D / Bed #20

Nature of problem or request: I am a high Blood and ~~diabetic~~ diabetic
and I take aspirin, I take 5 kinds of medicine.
I suppose to have 6/1 of my medicines is on P
on me, I just have one of them is on P.

Charles Hicks

Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
Time: AM PM
Allergies:

RECEIVED
Date: _____
Time: _____
Receiving Nurse Initials _____

(S)ubjective:

(O)bjective

(A)ssessment:

S/C
9/12/06
ABRN
12:25 pm

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
Check One: ROUTINE CIRCLE ONE
EMERGENCY If Emergency was PHS supervisor notified: Yes No
Was MD/PA on call notified: Yes No

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS

Nursing Evaluation Tool:

General Care

Facility: Alabama Department of Corrections	First Name: <u>Charles</u>
Patient Name: <u>Hicks</u>	Date of Birth: <u>11/12/61</u>
Inmate Number: <u>246241</u>	MM DD YYYY
Date of Report: <u>9 12 06</u>	Time Seen: <u>12:25 PM</u> Circ One

Subjective: Chief Complaint(s): I would like to get all my meds KOP.
 Onset: I'm supposed to get my BP v. I got checked

Brief History: A few days but feel it needs checking again.
 (Continue on back if necessary)

I'm getting my Diabetic medicine the morning
Nurse has an attitude, she's light skinned.

(2) I talked to a male here about a waitress and my left shoulder hurts.

Objective: Vital Signs: (As Indicated) T: 98.4 P: 72 RR: 12 BP: 140/90

Examination Findings: BP as above. Good ROM to left arm. No swelling
 (Continue on back if necessary)
in left or left shoulder.

Check for additional notes or

Assessment: (Referral Status)
 Referral NOT REQUIRED

Preliminary Determination(s):

Referral REQUIRED due to the following: (Check all that apply)

Recurrent Complaint (More than 2 visits for the same complaint)

Other:

Requests All meds KOP
Wants BP v's

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or appropriate care to be given.

Plan: Check All That Apply:

- Instructions to return if condition worsens.
- Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)
- Other:

(Describe)
 OTC Medications given NO YES (If Yes List):

Date for referral:

Referral: NO YES (If Yes, Where): MD

Referral Type: Routine Urgent Emergent (If emergent who was contacted):

A. Blackey R.N. Name: A. Blackey R.N.
 Nurses Signature Printed



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Charles Hicks Date of Request: 8-22-06
 ID # 246241 Date of Birth: 11-2-61 Location: _____

Nature of problem or request: To receive my medicine for
my diabetes and fluid for my leg. Carol Hicks
Blood pressure and Aspirin please.

Charles Hicks
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies: _____

RECEIVED	
Date:	_____
Time:	_____
Receiving Nurse Initials _____	

(S)ubjective:

(O)bjective

(A)ssessment:

(P)lan:

*9/23/06
ABRN
12:30P*

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()
 Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PES

Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name:

Hicks

Charles

Inmate Number:

246241

Last

First:

MI

Date of Birth:

11 12 161

MM

DD

YYYY

Date of Report:

8 123 106

MM

DD

YYYY

Time Seen:

12:30

AM / PM

Circle One

Subjective: Chief Complaint(s): Came back Monday from Court in Jefferson

Onset: County. Have not had any medicine since

Brief History: Sunday. I get Diabetic medicine, Lasix, BP medicine, Aspirin. I would like my medications restarted.

Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98 P: 72 RR: 12 B/P: 147 / 86

Examination Findings: On exam calm, oriented, cooperative.

(Continue on back if necessary)

Check Here if additional notes on back

Assessment: (Referral Status)

Preliminary Determination(s):

Referral NOT REQUIRED

Referral REQUIRED due to the following: (Check all that apply)

Recurrent Complaint (More than 2 visits for the same complaint)

Other: _____

*pick note on Aug MAR book from KOP
to give meds until stock arrives*

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

Instructions to return if condition worsens.

Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other: _____

(Describe)

OTC Medications given NO YES (If Yes List): _____

Referral: NO YES (If Yes, Whom/Where): _____

12/11/02

Date for referral: / /

MM DD YYYY

Referral Type: Routine Urgent Emergent (if emergent who was contacted?): _____

Time _____

John Blackmon

Name: _____

John Blackmon

Printed: _____

Nurses Signature



Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Hicks Charles
 Last _____
 Inmate Number: 246241 First _____ Date of Birth: 1/12/61 MI _____
 MM DD YYYY
 Date of Report: 1/1/06 Time Seen: _____ AM / PM Circle One

Subjective: Chief Complaint(s): Need to see MD not feeling well at all

Onset: Last week

Brief History: At times I feel very weak ie sunday before last
 (Continue on back if necessary)
I felt very weak as if to pass-out. I had my BS = 64.
After eating a sandwich I felt better. This occurred several
times but not as severe.

Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98² P: 66 RR: 18 B/P: 148/95

Examination Findings: NDX3. Noted 3am FS 1 then 3pm FS. average AM FS 7-10.
 (Continue on back if necessary)
PM FS = 7-90 (amt 116 + 84) (amt 171 + 63). On one occasion
they had nothing or refus for snack. Takes glucotrol 10mg qd foods
BP med taken daily. BP 148/95. Med taken for BP -
Lisinopril 20mg qd / Maxzide 75/50mg qd / ASA BC 325mg qd.

Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):

Referral NOT REQUIRED

Referral REQUIRED due to the following: (Check all that apply)

Recurrent Complaint (More than 2 visits for the same complaint)

Other: TBI

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

44 y/o request eggcrate mattress (HT 6'5" wt 258 lbs)

Instructions to return if condition worsens.

Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other:

(Describe)

OTC Medications given NO YES (If Yes List):

Referral: NO YES (If Yes, Whom/Where): HCCU service Date for referral: 5/31/06

Referral Type: Routine Urgent Emergent (if emergent who was contacted?) _____ Time _____

X

J. L. B. con
 Nurses Signature

Name: G. Lysykawycz
 Printed



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 8/2/06
ID # 246241 Date of Birth: 11-2-61 Location: 200m/Bed 20
Nature of problem or request: I need to see a doctor real
bad because i am not feeling well at
all. As soon as possible. I am having trouble
with my left shoulder, and my diabetes and blood
Charles Hicks Presu
Signature

DO NOT WRITE BELOW THIS LINE

Date: ____ / ____ / ____
Time: _____ AM PM
Allergies: _____

RECEIVED
Date: 8/2/08
Time: 10:44 pm
Receiving Nurse Initials JP

(S)ubjective:

(O)bjective

(A)ssessment:

(P) Jan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

FLYC

Facility: Alabama Department of Corrections	
Patient Name:	<i>Nick Charles</i>
Inmate Number:	<i>246241</i>
Date of Report:	<i>6/12/06</i>
First Date of Birth:	<i>11/12/61</i>
Time Seen:	<i>3:25 AM</i>
AM/PM	<i>AM</i>
AM/PM	<i>AM</i>

Subjective: Chief Complaint(s): *BBP / missing Marx/meds resolved*
 Onset: *24 years*

Brief History: *Had problems w/ edema in R leg since high school*
 (Continue on back if necessary)

Objective: Vital Signs: (As Indicated) T: _____ P: _____ RR: _____ B/P: _____

Examination Findings: *100x3. No diff elevating on R. Bunk due to edema in R leg at level of (1-10) when weight applied. Occasional pain when walking or pain standing. States keeps R leg elevated when able. Noted edema R ankle to mid calf about 2x size of L leg.*

Assessment: (Referral Status) Preliminary Determination(s): *Check here for additional notes on back*

Referral NOT REQUIRED

Referral REQUIRED due to the following: (Check all that apply)

Recurrent Complaint (More than 2 visits for the same complaint)

Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

Instructions to return if condition worsens.

Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other: _____

(Describe)
 OTC Medications given NO YES (If Yes List): _____

Referral: NO YES (If Yes, Whom/Where): *HCC, review* Date for referral: *6/12/06*

Referral Type: Routine Urgent Emergent (if emergent who was contacted?): _____ Time _____

He B. Ba
 x _____
 Nurses Signature

Name: *G. Lengkongco, RN*
 Printed



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Charles Hicks Date of Request: 6-10-06
 ID # 246241 Date of Birth: 11-2-61 Location: 4-Dorm
 Nature of problem or request: Med'cne for my Diabetes, Blood
pressure And LASSic for my legs, And to check
my blood Pressure and Blood SUGAR.

Charles Hicks
 Signature

DO NOT WRITE BELOW THIS LINE

Date: 6/11/06
 Time: 5 pm AM PM
 Allergies: _____

RECEIVED
 Date: 6-11-06
 Time: 5 pm
 Receiving Nurse Initials: RL

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Charles Hicks Date of Request: 6-10-06
 ID # 246241 Date of Birth: 10-20-61 Location: 4-Dorm
 Nature of problem or request: Medicine for my Diabetes. I want
Prescription for Lassie for my dog. And to check
my blood pressure and blood sugar.

Charles Hicks

Signature

DO NOT WRITE BELOW THIS LINE

Date: 6/10/06
 Time: 5 PM AM PM
 Allergies: _____

RECEIVED	
Date:	<u>6-10-06</u>
Time:	<u>5 PM</u>
Receiving Nurse Initials <u>CH</u>	

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PROGRESS NOTES

Date/Time	Inmate's Name: Hicks Charles Bm 246241 D.O.B.: 11/12/61
6/21/06 9:00 AM	Blue jacket recd @ tdc/office. Smeds Vol 1 of 1 recd - yearly
10/24/06 1800	Admitted to Main Bed #6 for FWA. Alert 0x4 Resp - ease. Skin w/ D to touch. (L) Leg edema + ext.
10/26/06 3:25 PM	No complaints voiced. Will continue to monitor — <i>DM/bed</i> Inform pt of neg results of venous doppler. <i>J. Parker, CPN</i>



TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record Institution: <u>FLYC</u> Date: <u>6/18/06</u> Time: _____ AM/PM RECEIVED FROM: Institution/Work Release Center/Free-World Hospital <u>KMF</u>	RELEASED: Inmate/Health Record Institution: <u>Kilby</u> Date: <u>6/8/06</u> Time: _____ AM/PM RELEASE FROM: <input type="checkbox"/> Infirmary <input type="checkbox"/> Segregation <input checked="" type="checkbox"/> Population <input type="checkbox"/> Mental Health <input type="checkbox"/> Other _____	ALLERGIES: <u>NKA</u> PHYSICAL EXAMINATION Date of last exam: <u>5/19/06</u> Chest X-Ray Date: _____ Result: _____ PPD Reading <u>0 mm</u> Classification: _____ Limitations: _____
RECEIVING MEDICAL STATUS <input checked="" type="checkbox"/> Population <input type="checkbox"/> Infirmary <input type="checkbox"/> Isolation	RELEASE TO: <input checked="" type="checkbox"/> DOC <input type="checkbox"/> Infirmary <input type="checkbox"/> Mental Health <input type="checkbox"/> _____	Institution/Work Release Center/Free-World Hospital

LAB RESULTS -- LAST REPORT				YES	NO
CBC	Date 5/20/06 5/19/06	Normal <input checked="" type="checkbox"/> <input type="checkbox"/>	Abnormal <input type="checkbox"/> <input type="checkbox"/>	Wears Glasses/Contacts <input type="checkbox"/> <input type="checkbox"/>	
Urinalysis				Dental Prosthesis <input type="checkbox"/> <input type="checkbox"/>	
				Hearing Aide <input type="checkbox"/> <input type="checkbox"/>	
				Other Prosthesis <input type="checkbox"/> <input type="checkbox"/>	
				Receiving Nurse <i>C. Blush</i>	

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

JD Dm HTN

CURRENT MEDICATION - - DOSAGE AND FREQUENCY		See MAR	MEDICATIONS	<input type="checkbox"/> Sent w / inmate	<input type="checkbox"/> Not sent w / inmate
			X-RAY FILM	<input type="checkbox"/> Sent w / inmate	<input type="checkbox"/> Not sent w / inmate
			HEALTH RECORD	<input type="checkbox"/> Sent w / inmate	<input type="checkbox"/> Not sent w / inmate
			Released to:		
			Date:	Time:	AM/PM
			MEDICATIONS	<input type="checkbox"/> Received	<input checked="" type="checkbox"/> Not Received
			X-RAY FILM	<input type="checkbox"/> Received	<input checked="" type="checkbox"/> Not Received
			HEALTH RECORD	<input checked="" type="checkbox"/> Received	<input type="checkbox"/> Not Received
			CHART REVIEWED	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
			Received by:	C. Goldm	
			Signature of Receiving Nurse		
			Date:	Time:	AM/PM

FOLLOW-UP CARE NEEDED Date Time With Whom - - Location (Sending Nurse) Date/Appt. Made w/Whom (Rec. Nurse)

Medical Dental _____ _____ _____ _____

Mental Health _____ _____ _____ _____

		Yes	No
HISTORY	Drug Use	<input checked="" type="checkbox"/>	
	Mental Illness	<input checked="" type="checkbox"/>	
	Suicide Attempt	<input checked="" type="checkbox"/>	
	Chronic Care	<input checked="" type="checkbox"/>	
STATUS	Special Diet	<input type="checkbox"/>	
	Appearance	<input type="checkbox"/>	
OTHER PERTINENT NURSING ASSESSMENT <i>AB</i>			

NURSING ASSESSMENT (RECEIVING NURSE)

(Noted from inmate assessment)

		Yes	No
SKIN	Open Sores		<input checked="" type="checkbox"/>
	Lice		<input type="checkbox"/>
	Edema		<input type="checkbox"/>
	Warm & Dry		<input checked="" type="checkbox"/>
	Cool & Moist		<input type="checkbox"/>

CONDITION		
	Alert	<input checked="" type="checkbox"/>
	Oriented	<input checked="" type="checkbox"/>
	Uncooperative	<input type="checkbox"/>
	Depressed	<input type="checkbox"/>

INTAKE

Sick Call Procedures Explained

Height

Weight

Blood Pressure

Temperature

Pulse Resp.

Other _____

1

J. Yewelle LPN
Signature of Nurse Completing Assessment (Sitting Nurse)

6/18/06
Date

Signature of Intake Screening Nurse (Receiving Nurse)

Collage
Date

卷之三

Case 2:06-cv-00990

Facility Name:

FHC

Month/Year of Charting:

10/06

KCL 10mg PO
QAM x 2wks

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
GA	X																														

SP Start Date: 10-3-06 Prescriber: Mahood
Stop Date: 10-17-06 RX #:

Augmentin 875mg PO
BID x 10 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
GA	X																														
CP	X																														

SP Start Date: 10-3-06 Prescriber: Mahood
Stop Date: 10-13-06 RX #:

Motrin 400mg
PO BID

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
GA																															
CP																															

CP Start Date: 10/10/06 Prescriber: Corbin
Stop Date: 10/26/06 RX #:

Aspirin 400mg
PO BID

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
GA																															
CP																															

CP Start Date: 10/13/06 Prescriber: Corbin
Stop Date: 10/27/06 RX #:

Microk 10mg
2 po QD

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
GA																															
CP																															

CP Start Date: 10/13/06 Prescriber: Corbin
Stop Date: 10/27/06 RX #:

Motrin 400mg
BID prn x 2 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
GA																															
CP																															

CP Start Date: 10-30-06 Prescriber: Dr. Corbin
Stop Date: 11-1-06 RX #:

Diagnosis:

NKA

Initial:

NKA

Initial:

Documentation Codes

1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

Allergies:

NKA

Signature:

Initial:

Signature:

Initial:

Documentation Codes

Housing Unit:

246241

Signature:

Initial:

Signature:

Initial:

Documentation Codes

Patient ID Number:

246241

Patient Name:

Hicks, Charles

Date of Birth:

4

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Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
	<i>Verda Reeder</i>	<i>S</i>	<i>See Johnson Spw</i>	<i>Q</i>	1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other
Allergies	<i>C Thomas</i>	<i>CT</i>			
Housing Unit:	<i>6AII</i>				
Patient ID Number:	199225				
Patient Name:					
Hicks, Charles			Date of Birth:		

Facility Name:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
0700	→ 9		DC		Month/Year of Charting:																										
2000	→ 11		SEE new order																												
Review p 30 days																															
Start Date:	5/3/06		Prescriber:	Baru / Philmore nc																											
Stop Date:	6/12/06		RX #:																												

Vasotec 10mg 1 dose

Now

5/4/06 Baru / Thomas

Vasotec 20mg
Q AM X 30 daysVasotec 10mg
PO Q HS X 30 daysVasotec 10mg
PO X 1 dose
Now

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
	Scasky	IN	C Thomas	C7	1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other
Allergies			See physician for	87	
NKA					
Housing Unit: 6A11					
Patient ID Number: 199 225					
Patient Name: Hicks, Charles			Date of Birth:	11/12/61	

II of II

Facility Name: FLC

Month/Year of Charting: 9/06

HCTZ 25mg t po
qd x 90 days

not KAP

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
6A																														

Lisinopril 20mg t
po qd ^{genus} BID x
90 days

not KAP

mr	Start Date: 9/13/06	Prescriber: Corbier, MD
	Stop Date: 12/13/06	RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
6A																														

mr	Start Date: 9/13/06	Prescriber: Corbier, MD
	Stop Date: 12/13/06	RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
F																														

J	Start Date:	Prescriber:
	Stop Date:	RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

✓	Start Date:	Prescriber:
	Stop Date:	RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

✓	Start Date:	Prescriber:
	Stop Date:	RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

✓	Start Date:	Prescriber:
	Stop Date:	RX #:

Diagnosis: NKDA

Nurse's Signature: M. Robinson, RN

Initial: J. Parkey, RN

Allergies: NKDA

Housing Unit: 246241

Patient Name: Hicks, Charles

Documentation Codes:

1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

Date of Birth:

11/2/01

Facility Name:	Frank Lee Youth Center	Month/Year of Charting:	09/06																												
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Maxzide 75-50MG Tab	30.00	6A M H M M B M B K H M D/C at close me																													
Take 1 tablet(s) by mouth daily																															
Kop																															
Aspirin EC 325MG EC Tab	30.00	6A M H M M B M B K H M Charles Hicks #30 9/16/06																													
Take 1 tablet(s) by mouth daily																															
Kop																															
Glucotrol 10MG Tab	30.00	6A M H M M B M B K H M Charles Hicks #30 9/16/06																													
Take 1 tablet(s) by mouth daily																															
Kop																															
Mevacor 40MG Tab	15.00	6A M H M M B M B K H M Charles Hicks #30 9/16/06																													
Take one-half (1/2) tablet(s) by mouth daily																															
20mg Kop																															
Lisinopril 20mg po QD																															
Kop																															
Bacitracin DS 1 po Bid																															
Diagnosis	Nurse's Signature												Initial	Nurse's Signature												Initial	Documentation Codes				
Allergies	Capodilene												80	J. Parker, RN JP													1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other				
Housing Unit:	Population																														
Patient ID Number:	246241																														
Patient Name:	Hicks, Charles													Date of Birth												11/21/61					

Drug Interaction Report

Generated: 9/6/2006 6:07:44 PM

To: Corbier, Paul

Facility: Frank Lee Youth Center

Housing Unit: Population

Patient Name: Hicks, Charles

ID Number: 246241

Drug Name: Lisinopril / 20MG / Tab

Severity: Major

Interaction: Lisinopril / 20MG / Tab with Maxzide 75-50MG Tab

Summary: Hyperkalemia, possibly with cardiac arrhythmias or arrest, may occur with the combination of Maxzide and Lisinopril / 20MG / Tab. Serum potassium concentrations should be monitored.

For additional information regarding the potential management of this drug information, please contact the Secure Pharmacy Plus Drug information Center at 1-800-833-2510 x 1724.

Done

Facility Name:	Frank Lee Youth Center	Month/Year of Charting:	08/06
Maxzide 75-50MG Tab	30.00	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
Take 1 tablet(s) by mouth daily		6A	
(KOP)		6A	
Aspirin EC 325MG EC Tab	30.00	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
Take 1 tablet(s) by mouth daily		6A	
(KOP)		6A	
Glucotrol 10MG Tab	30.00	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
Take 1 tablet(s) by mouth daily		6A	
(KOP)		6A	
Mevacor 40MG Tab	15.00	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
Take one-half (1/2) tablet(s) by mouth daily		6A	
(KOP)		6A	
<i>Lesinopril 20mg po q d x 180 days</i>		6A	
		Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
		6A	
		Start Date:	05-22-2006
		Prescriber:	Lassiter, L.
		Stop Date:	11-17-2006
		RX #:	251540568
		Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
		6A	
		Start Date:	05-22-2006
		Prescriber:	Lassiter, L.
		Stop Date:	11-17-2006
		RX #:	251540569
		Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
		6A	
		Start Date:	05-22-2006
		Prescriber:	Lassiter, L.
		Stop Date:	11-17-2006
		RX #:	251540573
		Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
		6A	
		Start Date:	8/15/06
		Prescriber:	Howard Camp
		Stop Date:	2/15/07
		RX #:	
		Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
		6A	
		Start Date:	
		Stop Date:	
		Give meds from Stock until KOP available.	
Diagnosis	NKA		Nurse's Signature
Allergies			
Housing Unit:	Population		Initial
Patient ID Number:	246241		Documentation Codes
Patient Name:	Hicks, Charles		1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other
		Date of Birth:	11-4-61

Facility Name:	Frank Lee Youth Center	Month/Year of Charting:	07/06				
Vasotec 5MG Tab	30.00	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30				
Take 1 tablet(s) by mouth daily		6A	6A				
		Start Date:	06-01-2006				
		Prescriber:	Robbins, M.				
		Stop Date:	11-27-2006				
		RX #:	251575009				
Maxzide 75-50MG Tab	30.00	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30				
Take 1 tablet(s) by mouth daily		6A	6A				
		Start Date:	05-22-2006				
		Prescriber:	Lassiter, L.				
		Stop Date:	11-17-2006				
		RX #:	251540566				
Aspirin EC 325MG EC Tab	30.00	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30				
Take 1 tablet(s) by mouth daily		6A	6A				
		Start Date:	05-22-2006				
		Prescriber:	Lassiter, L.				
		Stop Date:	11-17-2006				
		RX #:	251540568				
Glucotrol 10MG Tab	30.00	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30				
Take 1 tablet(s) by mouth daily		6A	6A				
		Start Date:	05-22-2006				
		Prescriber:	Lassiter, L.				
		Stop Date:	11-17-2006				
		RX #:	251540569				
Mevacor 40MG Tab	15.00	Hour	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30				
Take one-half (1/2) tablet(s) by mouth daily		6A	6A				
		Start Date:	05-22-2006				
		Prescriber:	Lassiter, L.				
		Stop Date:	11-17-2006				
		RX #:	251540573				
Diagnosis	NKA		Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies	NKA		S. Taylor	st	M. Williams	MS	1. Discontinued Order
Housing Unit:	Population						2. Refused
Patient ID Number:	246241						3. Patient out of facility
Patient Name:							4. Charted in Error
Hicks, Charles				Date of Birth:	11-2-61		5. Lock Down
							6. Self Administered
							7. Medication out of Stock
							8. Medication Held
							9. No Show
							10. Other

I of II

Facility Name: KCF

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
maxzide 75/50 0300 AM NK																															
po gd x 1800 DP																															

(Triamterene - HCTZ)

ECA 325mg 0300 AM NK
+ po gd x 1800 DPGlucotrol 10mg 0500 AM NK
+ po gd x 1800 DP

(Glipizide)

mevacor 20mg 0500
+ po gd x 1800 DP

(Lorvastatin)

AFC BID x 30d
use as directed
thin layerVit. A&D oint.
use as directed
BID x 30d

Diagnosis

Allergies NKDA

Housing Unit:

Patient ID Number:

Patient Name: 246241

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date: 5-19-06																															
Stop Date: 11-20-06																															

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date: 5-19-06																															
Stop Date: 11-20-06																															

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date: 5-19-06																															
Stop Date: 11-20-06																															

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
K																															
D																															

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
P Given 5-19-06																															
Start Date: 5-19-06																															
Stop Date: 6-19-06																															

Initial	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Code:
	Mandy		DP		1. Discontinued Order
	nk				2. Refused
					3. Patient out of facility
					4. Charted in Error
					5. Lock Down
					6. Self Administered
					7. Medication out of Stock
					8. Medication Held
					9. No Show

PRISON HEALTH SERVICES AUTHORIZATION LETTER

Patient Name:	Hicks, Charles	Inmate Number:	246241HI
Service Authorized:	X-Ray: Doppler Study - Standard Cost	Effective Dates:	10/18/2006
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Staton Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	16609600	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
 P.O. Box 967
 Brentwood, TN 37024-0967

The consulting physician should complete this section.
 The completed form will be sealed in the attached envelope and
 returned with an officer to the correctional facility.

Clinical Summary or Attached Report

*** For security and safety, please do not inform patient of possible follow-up appointments. ***

Signature of Consulting Physician:

Date _____ Time _____

Reviewed and Signed By
 Medical Director:

Date _____ Time _____

Patient Name:	Hicks, Charles	Inmate Number:	246241HI
Service Authorized:	Office Visits: Op General Specialty Referral	Effective Dates:	10/13/2006
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Staton Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	16589490	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
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Prison Health Services
 P.O. Box 967
 Brentwood, TN 37024-0967

**The consulting physician should complete this section.
 The completed form will be sealed in the attached envelope and
 returned with an officer to the correctional facility.**

Clinical Summary or Attached Report

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician:	Date	Time
Reviewed and Signed By Medical Director:	Date	Time

Please send this for

must be complete and legible. You must type or print the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number:	Patient Name: (Last, First.)	Date: (mm/dd/yy)
Station 843	Micks, Charles	10/12/06
Site Phone #	Alias: (Last, First.)	Date of Birth: (mm/dd/yy)
(334) 567-1548		110216
Site Fax #	Inmate #	PHS Custody Date: (mm/dd/yy)
(334) 567-1538	246241	4/13/06
Will there be a charge?	SS Number	Potential Release Date: (mm/dd/yy)
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	400-96-0383	11/20/08

Responsible party: PHS Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans*)
 Auto Ins. Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: Physician NP, PA Dental

Paul Corbier

Facility Medical Director Signature and Date:

Paul Corbier 10/12/06

Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

<input type="checkbox"/> Office Visit (OV)	<input type="checkbox"/> X-ray (XR)	<input type="checkbox"/> Scheduled Admission (SA)
<input type="checkbox"/> Outpatient Surgery (OS)	<input type="checkbox"/> Dialysis (DA)	
<input checked="" type="checkbox"/> Routine	<input type="checkbox"/> Urgent	

Estimated Date of Service (mm/dd/yy) 1/1/07

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: Radiation therapy

Number of Visits/Treatments: Chemotherapy

Other:

Specialist referred to: *Harshbarger Orthotist*

Type of Consultation, Treatment, Procedure or Surgery:

Request for Diabetic Shoes

Diagnosis: DM Diabetic neuropathy Venous insufficiency

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

Pertinent Documents have been attached and faxed.

UM DETERMINATION:

Offsite Service Recommended and Authorized

Alternative Treatment Plan (explain here):

[Large empty box for alternative treatment plan]

More Information Requested: (See Attached)

[Large empty box for more information]

Date resubmitted:

Resubmitted with requested information.

[Large empty box for resubmission]

Regional Medical Director Signature,
printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

CPT code:

UR Auth #:



FAXED AM 10/13/06

Please send this for

must be Complete and Legible. You must type or print the Authorization Letter to the service provider and attach it to this form.

of the Appointment

Site Name & Number:

Station 843

Patient Name: (Last, First.)

Hicks, Charly

Date: (mm/dd/yy)

10/13/06

Site Phone #

(334) 567-1548

Alias: (Last, First.)

Date of Birth: (mm/dd/yy)

11/04/06

Site Fax #

(334) 567-1538

Inmate #

246241

PHS Custody Date: (mm/dd/yy)

9/3/06

Will there be a charge?

 Yes NoSex
 Male Female

SS Number

420-90-0383

Potential Release Date: (mm/dd/yy)

11/20/08

Responsible party:

 PHS Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans) Auto Ins. Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider:

 Physician NP, PA Dental

Paul Cribes, MD

Facility Medical Director Signature and Date:

Paul Cribes 10/13/06

 Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

 Office Visit (OV) X-ray (XR) Scheduled Admission (SA) Outpatient Surgery (OS) Dialysis (DA) Routine Urgent

Estimated Date of Service (mm/dd/yy)

10/13/06

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: Radiation therapy Chemotherapy Other:

Number of Visits/Treatments: _____

Specialist referred to: FMI

Type of Consultation, Treatment, Procedure or Surgery:

Venus Doppler (1) leg

Diagnosis: (1) Leg swelling/pain NO DVT

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

 Pertinent Documents have been attached and faxed.

UM DETERMINATION:

 Offsite Service Recommended and Authorized Alternative Treatment Plan (explain here):

Date resubmitted:

 More Information Requested: (See Attached) Resubmitted with requested information.
Regional Medical Director Signature,
printed name and date required:

Previous treatment and response (including medications):

- Diuretic therapy
- Support stockings.

For security and safety, please do not inform patient of possible follow-up appointments

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Usa - UM Referral Review Form

received 10/17/06 JMI faced 10/17/06



Date: 10/25/2006
 Patient: Hicks, Charles
 DOB: 11/2/1961
 Physician: P. Corbier, MD
 Tech: Amy Waite, RT
 Chart #: PAT000020360
 Indication: Left leg edema greater
 than 5 years, painful

SCAN: Bilateral lower extremity Doppler ultrasound.

TECHNIQUE: Bilateral lower extremity venous Doppler was performed in the usual manner.

FINDINGS:

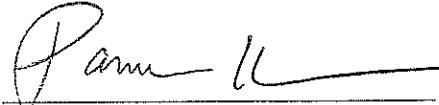
Right extremity: The patient had normal compression, augmentation and flow in the deep venous system of the right extremity.

Left extremity: The patient had calcifications and edema in the region of the left posterior tibial vein. There was normal compression, flow and augmentation of the deep venous system of the left extremity.

IMPRESSION:

1. Exam negative for DVT in the right leg.
2. Scattered calcifications and edema surrounding the left posterior tibial vein. No thrombus was identified.

Thank you for this patient referral.


 P. Kulback, MD
 PK/bk
 D:10/25/2006
 T:10/26/2006



Date: 10/25/2006
 Patient: Hicks, Charles
 DOB: 11/2/1961
 Physician: P. Corbier, MD
 Tech: Amy Waite, RT
 Chart #: PAT000020360
 Indication: Left leg edema greater
 than 5 years, painful

SCAN: Bilateral lower extremity Doppler ultrasound.

TECHNIQUE: Bilateral lower extremity venous Doppler was performed in the usual manner.

FINDINGS:

Right extremity: The patient had normal compression, augmentation and flow in the deep venous system of the right extremity.

Left extremity: The patient had calcifications and edema in the region of the left posterior tibial vein. There was normal compression, flow and augmentation of the deep venous system of the left extremity.

IMPRESSION:

1. Exam negative for DVT in the right leg.
2. Scattered calcifications and edema surrounding the left posterior tibial vein. No thrombus was identified.

Thank you for this patient referral.

A handwritten signature in black ink, appearing to read 'P. Kulback'.

P. Kulback, MD
PK/bk
D:10/25/2006
T:10/26/2006

A handwritten signature in black ink, appearing to read 'SC'.



74240 Tallasseee Hwy
Wetumpka, AL 36092
Phone: 334-567-8383
Fax: 334-567-1880

www.myimi.org
A Division of Ransom & Hartl, Inc.

7094 University Court
Montgomery, AL 36117
Phone: 334-271-1345
Fax: 334-271-1342



10/06/2006 FRI 15:25 FAX 334 to 1538 Staton Health Unit

008/036

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print
Please send this form with the Authorization Letter to the service provider at the time of the Appointment

RECEIVED

DEMOGRAPHICS

Site Name & Number:

Staton 843

Patient Name: (Last, First)

Hicks, Charles

Date: (mm/dd/yy)

10/03/06

Site Phone #

(334) 567-1548

Alias: (Last, First)

Date of Birth: (mm/dd/yy)

11/02/61

Site Fax #

(334) 567-1538

Inmate #

246241

PHS Custody Date: (mm/dd/yy)

4/13/06

Will there be a charge?

 Yes No

Sex

 Male Female

SS Number

420-960383

Potential Release Date: (mm/dd/yy)

11/20/28

Responsible party:

 PHS Auto Ins. Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans.) Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services).

CLINICAL DATA

Requesting Provider: Physician NP, PA Dental

Megan Mahood, CRNP

Facility Medical Director Signature and Date:

Paul Corbier 10/3/06

 Service meets criteria for "approval via protocol".

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

 Office Visit (OV) Emergency (ER) Scheduled Admission (SA) Outpatient Surgery (OS) Dialysis (DA) Routine Urgent

Estimated Date of Service (mm/dd/yy)

1 1

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: Radiation therapy Chemotherapy Other:

Specialist referred to: IMI

Type of Consultation, Treatment, Procedure or Surgery:

B Venous doppler of lower extremities

Diagnose: Peripheral vascular disease

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

 Pertinent Documents have been attached and faxed.

UM DETERMINATION:

 Offsite Service Recommended and Authorized Alternative Treatment Plst (explain how): More Information Required: (See Attached) Resubmitted with requested information.

Date resubmitted:

Regional Medical Director Signature,
printed name and date required:

(P a 06)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: DP RL

Med Class: 93965

UR Auth #: 16573674

USA - UM Referral Review Form

E. Elliott, M.D.

PATIENT: Name Charles Hicks D.O.B. 11/3/61
 CPT/ICD: Code Station
 PROVIDER: Name Dr. Paul Corbier
 Signature Paul Corbier

ID# 246241 GROUP#

Service Date

ID# _____ Phone# _____

Date

ICD-9-CM: 88.60, 88.66, 88.67

CPT: 75820, 75822

INDICATIONS (choose one and see below)

- 100 Suspected lower extremity DVT
- 200 Suspected upper extremity DVT
- 300 Evaluation of venous patency
- 400 Preoperative evaluation of varicosities
- 500 Mapping of the venous system prior to bypass surgery
- Indication Not Listed (Provide clinical justification below)*

100 Suspected lower extremity DVT(BOTH)

- 110 Sx/findings(TWO)
 - 111 Pain/tenderness in thigh/calf/ankle
 - 112 Edema/swelling in thigh/calf/ankle
 - 113 Homan's sign positive
 - 114 D-dimer assay positive
 - 115 High-risk for DVT
- 120 Duplex US(ONE)
 - 121 Nondiagnostic for lower extremity DVT
 - 122 Not feasible

200 Suspected upper extremity DVT(BOTH)

- 210 Sx/findings(TWO)
 - 211 Pain/tenderness in arm/forearm
 - 212 Edema/swelling in arm/forearm
 - 213 D-dimer assay positive
- 220 Duplex US(ONE)
 - 221 Nondiagnostic for upper extremity DVT
 - 222 Not feasible

300 Evaluation of venous patency(BOTH)

- 310 New Sx/findings
- 320 Post vascular reconstruction/angioplasty/thrombolysis

400 Preoperative evaluation of varicosities

*InterQual® criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.

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MCKESSON



LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN 264-205-5298-0	TYPE S	PRIMARY LAB MB	REPORT STATUS COMPLETE	Page #: 1
ADDITIONAL INFORMATION				
FLYC		FASTING: Y DOB: 11/02/1961		
PATIENT NAME HICKS,CHARLES		SEX M	AGE(YR./MOS.) 44 / 10	
PT. ADD.:				
DATE OF COLLECTION TIME 9/21/2006	DATE RECEIVED 7:52	DATE REPORTED 9/22/2006	TIME 8:33	8042

CLINICAL INFORMATION	
CD-41147612641	
PHYSICIAN ID. CORBIER P	PATIENT ID. 246241
ACCOUNT: Staton Correctional Facility Prison Health Services PO BOX 56 Elmore AL 36025-0000	
ACCOUNT NUMBER: 01308900	

TEST	RESULT	LIMITS	LAB
Microalbumin, Random Urine			
> Microalbum., U, Random	22.2 H ug/mL	0.0 - 17.0	MB
LAB: MB LabCorp Birmingham 1801 First Avenue South, Birmingham, AL 35233-0000		DIRECTOR: John Elgin N MD	

On 9/26/2006
9/26/2006
JL

Pat Name: HICKS,CHARLES	Pat ID: 246241	Spec #: 264-205-5298-0	Seq #: 8042
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Results are Flagged in Accordance with Age Dependent Reference Ranges

Last Page of Report

-2
115084-840

Keye

FINGER STICK BLOOD RECORD FORM

INSTITUTION/FACILITY:

I.D. # 246241

D.O.B.: 11-26-61

NAME: TRICIA, CHARLES

CELL SITE:

PHYSICIAN ORDER/INSTRUCTIONS:

BSVS 3A + 3p x 3d

**Check if results called to physician.*

05/25/2006 7:13:16

ID: #STAT#060525071317

SINUS RHYTHM

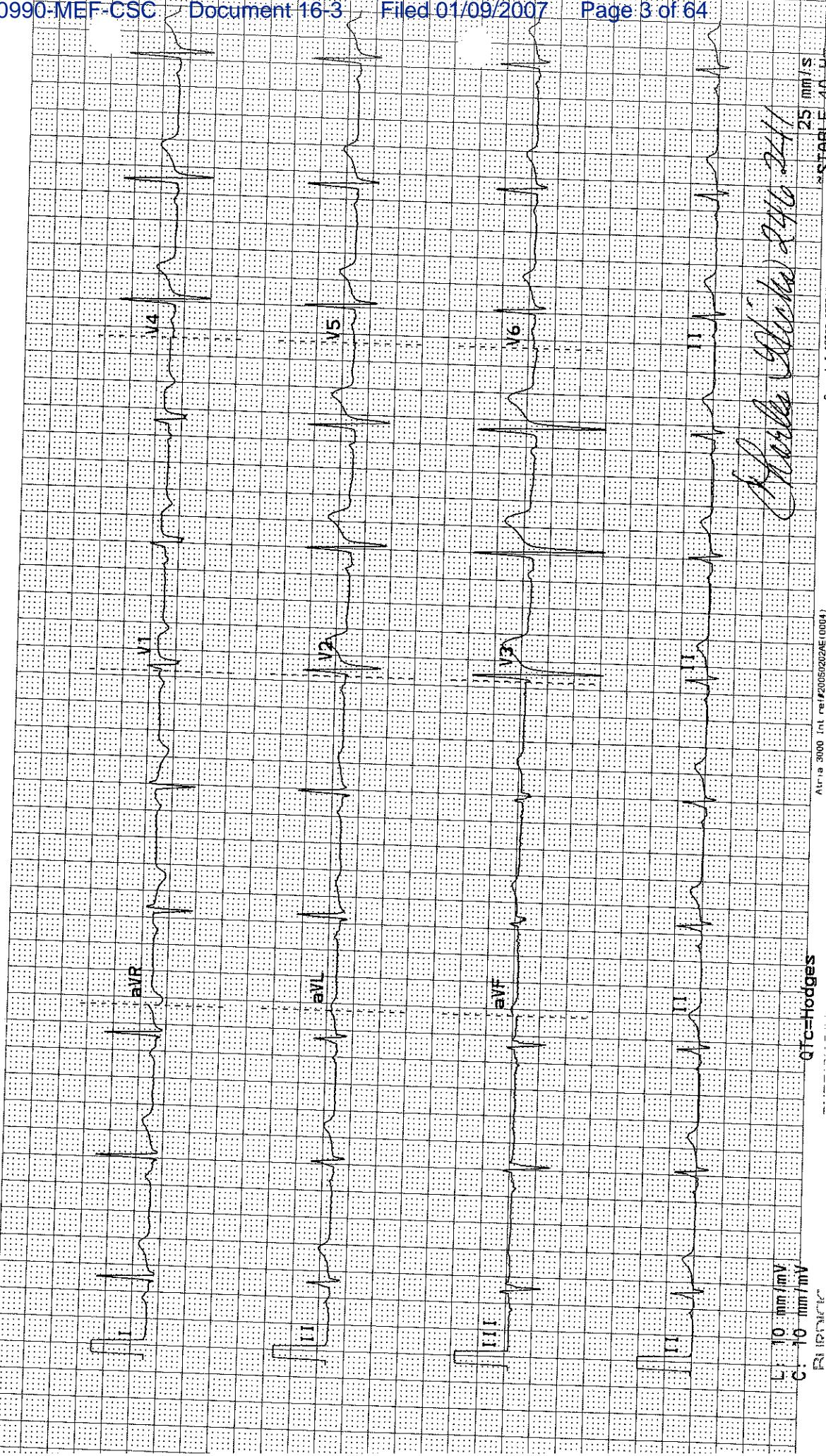
** INTERPRETATION MADE WITHOUT KNOWING PATIENT'S GENDER/AGE **
WITHIN NORMAL LIMITS

D.O.B.: 1/12/61
Meds:
Class:
Dr:
Tech:
Charles Hoddess
44
2/5 21255

* Unconfirmed Analysis *

Summary: NORMAL ECG

10 mm/mV
25 mm/s
QTc=Hodges




 LabCorp Birmingham
 1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #:
142-205-5362-0	S	MB	COMPLETE	1

ADDITIONAL INFORMATION

PE18 5/19	FASTING: N DOB: 11/02/1961
PATIENT NAME HICKS,CHARLES	SEX M
PT. ADD.:	AGE(YR./MOS.) 44 / 6

DATE OF COLLECTION TIME	DATE RECEIVED	DATE REPORTED	TIME	
5/22/2006 11:05	5/22/2006	5/23/2006	9:31	957

CLINICAL INFORMATION	
CD- 41139331447	
PHYSICIAN ID. ROBBINS M	PATIENT ID. 246241
ACCOUNT: Kilby Correctional Facility Prison Health Services 12201 Wares Ferry Road Mt. Meigs AL 36507-0000	
ACCOUNT NUMBER: 01306900	

TEST	RESULT	LIMITS	LAB
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CMP14+LP+5AC

Chemistries

> Glucose, Serum	132 H	mg/dL	65 - 99	MB
Uric Acid, Serum	5.4	mg/dL	2.4 - 8.2	MB
BUN	15	mg/dL	5 - 26	MB
Creatinine, Serum	1.3	mg/dL	0.5 - 1.5	MB
BUN/Creatinine Ratio	12		8 - 27	
Sodium, Serum	138	mmol/L	135 - 148	MB
Potassium, Serum	4.6	mmol/L	3.5 - 5.5	MB
Chloride, Serum	101	mmol/L	96 - 109	MB
Carbon Dioxide, Total	20	mmol/L	20 - 32	MB
Calcium, Serum	10.1	mg/dL	8.5 - 10.6	MB
> Phosphorus, Serum	5.0H	mg/dL	2.5 - 4.5	MB
Protein, Total, Serum	8.0	g/dL	6.0 - 8.5	MB
Albumin, Serum	4.3	g/dL	3.5 - 5.5	MB
Globulin, Total	3.7	g/dL	1.5 - 4.5	
A/G Ratio	1.2		1.1 - 2.5	
Bilirubin, Total	0.2	mg/dL	0.1 - 1.2	MB
Alkaline Phosphatase, Serum	88	IU/L	25 - 150	MB
LDH	194	IU/L	100 - 250	MB
AST (SGOT)	26	IU/L	0 - 40	MB
ALT (SGPT)	41	IU/L	0 - 55	MB
> GGT	75 H	IU/L	0 - 65	MB
Iron, Serum	57	ug/dL	40 - 155	MB
				MB

Lipids

> Cholesterol, Total	217 H	mg/dL	100 - 199	MB
> Triglycerides	156 H	mg/dL	0 - 149	MB
HDL Cholesterol	42	mg/dL	40 - 59	MB
VLDL Cholesterol Calc	31	mg/dL	5 - 40	
> LDL Cholesterol Calc	144 H	mg/dL	0 - 99	

Comment

If initial LDL-cholesterol result is >100 mg/dL, assess for risk factors.

> T. Chol/HDL Ratio	5.2H	ratio units	0.0 - 5.0
Estimated CHD Risk	1.0	times avg.	0.0 - 1.0

T. Chol/HDL Ratio

Men Women

1/2 Avg.Risk 3.4 3.3

Avg.Risk 5.0 4.4

Pat Name: HICKS,CHARLES	Pat ID: 246241	Spec #: 142-205-5362-0	Seq #: 957
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Results are Flagged in Accordance with Age Dependent Reference Ranges

Continued on Next Page



LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #:
142-205-5362-0	S	MB	COMPLETE	2

ADDITIONAL INFORMATION

PE18 5/19	FASTING: N DOB: 11/02/1961
PATIENT NAME HICKS,CHARLES	SEX M
PT. ADD.:	

DATE OF COLLECTION	TIME	DATE RECEIVED	DATE REPORTED	TIME	
5/22/2006	11:05	5/22/2006	5/23/2006	9:31	957

CLINICAL INFORMATION	
CD- 41139331447	
PHYSICIAN ID. ROBBINS M	PATIENT ID. 246241
ACCOUNT: Kilby Correctional Facility Prison Health Services 12201 Wares Ferry Road Mt. Meigs	AL 36507-0000
ACCOUNT NUMBER: 01306900	

TEST	RESULT	LIMITS	LAB
	2X Avg.Risk 9.6 7.1		
	3X Avg.Risk 23.4 11.0		

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

Microalb/Creat Ratio, Randm Ur

Creatinine, Urine	168.8	mg/dL	Not Estab.	MB
> Microalbum.,U,Random	51.3H	ug/mL	0.0 - 17.0	MB
> Microalb/Creat Ratio	30.4H	ug/mg creat	0.0 - 30.0	
Hemoglobin A1c				

> Alc	7.6H	%	4.5 - 5.7	MB
Current guidelines recommend a treatment goal of <7% for diabetic patients. Alc may be overestimated in diabetic patients exhibiting poor control and who are also heterozygous or homozygous for HgbS or HgbC. Total glycohemoglobin is a better indicator of diabetic control in patients with these hemoglobin variants.				

TSH 1.353 uIU/mL 0.350 - 5.500 MB

LAB: MB LabCorp Birmingham 1801 First Avenue South, Birmingham, AL 35233-0000	DIRECTOR: John Elgin N MD
--	---------------------------

Pat Name: HICKS,CHARLES	Pat ID: 246241	Spec #: 142-205-5362-0	Seq #: 957
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Results are Flagged in Accordance with Age Dependent Reference Ranges

Last Page of Report



LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #:
142-205-5362-0	S	MB	COMPLETE	1

ADDITIONAL INFORMATION

PE18
5/19
FASTING: N
DOB: 11/02/1961

PATIENT NAME	SEX	AGE(YR./MOS.)
HICKS,CHARLES	M	44 / 6

PT. ADD.:

DATE OF COLLECTION TIME	DATE RECEIVED	DATE REPORTED	TIME	
5/22/2006	11:05	5/22/2006	5/23/2006	9:31 957

TEST	RESULT	LIMITS	LAB
------	--------	--------	-----

CMP14+LP+5AC

Chemistries

> <input checked="" type="checkbox"/>	Glucose, Serum	132	H	mg/dL	65 - 99	MB
	Uric Acid, Serum	5.4		mg/dL	2.4 - 8.2	MB
	BUN	15		mg/dL	5 - 26	MB
	Creatinine, Serum	1.3		mg/dL	0.5 - 1.5	MB
	BUN/Creatinine Ratio	12			8 - 27	
	Sodium, Serum	138		mmol/L	135 - 148	MB
	Potassium, Serum	4.6		mmol/L	3.5 - 5.5	MB
	Chloride, Serum	101		mmol/L	96 - 109	MB
	Carbon Dioxide, Total	20		mmol/L	20 - 32	MB
	Calcium, Serum	10.1		mg/dL	8.5 - 10.6	MB
> <input checked="" type="checkbox"/>	Phosphorus, Serum	5.0H		mg/dL	2.5 - 4.5	MB
	Protein, Total, Serum	8.0		g/dL	6.0 - 8.5	MB
	Albumin, Serum	4.3		g/dL	3.5 - 5.5	MB
	Globulin, Total	3.7		g/dL	1.5 - 4.5	
	A/G Ratio	1.2			1.1 - 2.5	
	Bilirubin, Total	0.2		mg/dL	0.1 - 1.2	MB
	Alkaline Phosphatase, Serum	88		IU/L	25 - 150	MB
	LDH	194		IU/L	100 - 250	MB
	AST (SGOT)	26		IU/L	0 - 40	MB
	ALT (SGPT)	41		IU/L	0 - 55	MB
> <input checked="" type="checkbox"/>	GGT	75	H	IU/L	0 - 65	MB
	Iron, Serum	57		ug/dL	40 - 155	MB

Lipids

> <input checked="" type="checkbox"/>	Cholesterol, Total	217	H	mg/dL	100 - 199	MB
> <input checked="" type="checkbox"/>	Triglycerides	156	H	mg/dL	0 - 149	MB
	HDL Cholesterol	42		mg/dL	40 - 59	MB
	VLDL Cholesterol Cal	31		mg/dL	5 - 40	

> <input checked="" type="checkbox"/>	LDL Cholesterol Calc	144	H	mg/dL	0 - 99	MB
---------------------------------------	----------------------	-----	---	-------	--------	----

Comment

If initial LDL-cholesterol result is >100 mg/dL, assess for risk factors.

> <input checked="" type="checkbox"/>	T. Chol/HDL Ratio	5.2H	ratio units	0.0 - 5.0	
	Estimated CHD Risk	1.0	times avg.	0.0 - 1.0	

T. Chol/HDL Ratio

Men Women

1/2 Avg. Risk 3.4 3.3

Avg. Risk 5.0 4.4

Pat Name: HICKS,CHARLES	Pat ID: 246241	Spec #: 142-205-5362-0	Seq #: 957
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Results are Flagged in Accordance with Age Dependent Reference Ranges

Continued on Next Page





DEPARTMENT OF CORRECTIONS

DENTAL RECORD TREATMENT

Services Rendered

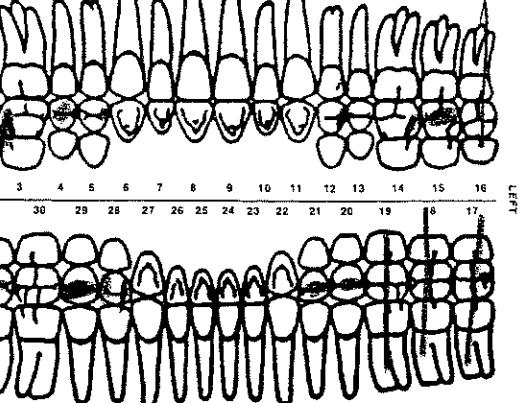
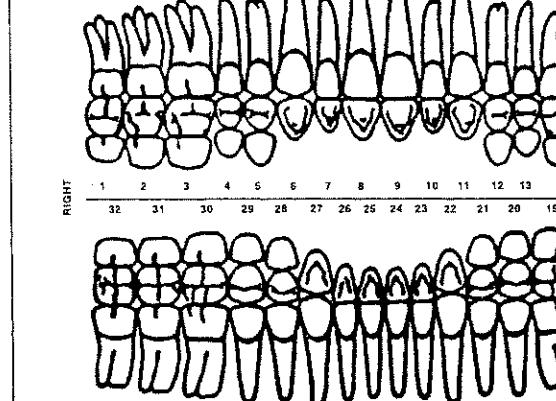
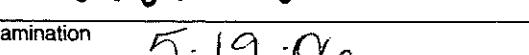
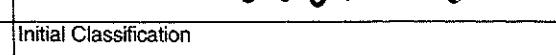
PATIENT LAST NAME	FIRST	MIDDLE	DOB	R/S	ID NO.



DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

DENTAL RECORD

DENTAL EXAMINATION																RESTORATIONS AND TREATMENTS																	
																																	
RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
																																	
Date of Initial Examination																Initial Classification																	
5-19-04																																	
Oral Pathology																Gingivitis																	
																Vincent's Infection																	
																Stomatitis																	
																Other Findings																	
Occlusion																																	
Roentgenograms																Periapical																	
																Bitewing																	
																Other																	

Health Questionnaire

SERVICES RENDERED

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Hicks, Charles	246241	11-2-01	B	KCF

ALABAMA DEPARTMENT OF CORRECTIONS

PROBLEM LIST

INMATE NAME Hicks, Charles **AIS#** 246241
Medication Allergies: NKA
Medical: Chronic (Long-Term) Problems
Roman Numerals for Medical Problems

Medical: Chronic (Long-Term) Problems Roman Numerals for Medical/Surgical Mental Health Code

for Medical/Surgical
Mental Health Code: SMI HARM HIST NONE
Capital Letter for Psychiatric Behavior

**If Asthmatic label: Mild - Moderate - or Severe.

KILBY CORRECTIONAL FACILITY
C A N T E E N S A L E S R E C E I P T

HICKS, CHARLES

246241

B/M

6/02/2006

3:35PM

TRANS NR

98845

ITEM LI	ISSUE NBR	QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	934	1	HONEY BUN	EA	\$.67	\$.67
***** LAST ITEM *****						=====
						TOTAL PURCHASES
						\$.67

OLD PMOD BALANCE

.70

TOTAL PURCHASE

.67

NEW PMOD BALANCE

.03

TOTAL APPLIED TO WEEKLY LIMIT .00

POSTED BY: INMATE WORKERS

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.

SIGNATURE

DATE

BED NBR: M 074B

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 7/15/06Time: Facility: FLYC

Medical history of mother has h/o Ceph

Check all applicable CIC's being evaluated: Card/HTN DM GI ID PUL SZ TB H7N9 D

H7N9 DM

HTN ONSET 1992 DM ONSET 2003

Mother

Father - HT

SUBJECTIVE: "Getting regular food, but urine orders for 2200cal ADA diet. Walk

approx. 2 miles Q.D. Denies tobacco user. Mother h/o DM & HTN + Eye exam @ Rely by 05/06. Mevacor 1st dose last week. Out of hospital X 2 months.

OBJECTIVE: BP 140/90 HR 64 RR 20 Temp 98 Wt 252 Peak Flow 02547-9750

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ

b/D Glucose X 30 days

Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds,

Glucose range 87-143

Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

NKA

meds

MAXZide 75/50

Ec ASA 325mg

Glucotrol

Mevacor 20mg QD

Varotac (Enalapril) 5mg QD

Total Chol. 2174

Trig 156

HDL 42

VLDL 144

LDL 144

Urine Cr. 16.8, 87

Microalbum 51.37

HbA1c 7.667

TSH 1.353

EKG 05/06 NSP

FINDINGS

Tender - Clear

SI-Sg-Asciulated P/B

Chest symmetric & clear

Abd soft & BS present

Tender, gurgly thick, distended

BPP 3/5 C/L + flat

distention

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's

Visit. Degree of Control: G=Good, F=Fair, P=Poor

Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER
Degree of Control						
G/F/P						
I	S	W	I	S	W	I
S	S	W	I	S	W	I
W	I	S	W	I	S	W

PLAN: ↑ Activities: ↓ Weight by 10. lbs (2 lbs weight loss per week)

② DIET - Change to 2200cal ADA

③ Fluorouracil to 20mg Q.D. & DC Varotac

④ DM - 65 ✓

Routine 90 days: 2X/DAY X 30 days

Other

⑤ Check lipid & microalbuminuria.

⑥ Check feet & legs

Problem List Updated: Yes

No

B. Howard Crenf

Physician/NP/PA

Hicks Charles

NAME

M

GENDER

B

RACE

246241

AIS#

11-2-61

DOB

(Revised 2/28/05)



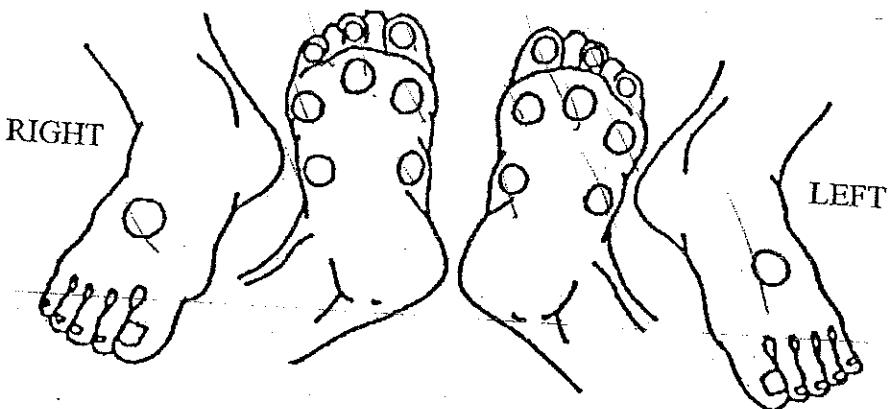
PRISON
HEALTH
SERVICES
INCORPORATED

MONOFILAMENT TESTING FOR DIABETICS

Fill in the following blanks with a "Y" or "N" to indicate findings

	RIGHT	LEFT
Is there a foot ulcer now?	N	N
Is there a history of foot ulcer?	N	N
Is there an abnormal shape of the foot?	N	N
Is there a toe deformity?	N	N
Are the toenails thick or ingrown?	N	N
Is there callus buildup?	Yes	Yes
Is there swelling?	NO	NO
Is there elevated skin temperature?	yes(M2L1)	Yes
Is there muscle weakness?	N	N
Can the inmate see the bottom of feet?	Yes	Yes
Is the inmate wearing improperly fitting shoes?	NO/Yes	NO/Yes BH
Does the inmate use footwear appropriate?	Yes	Yes
Pulses? 3/2 (4/4)	DP/PT 4/3	+/-

Note the level of sensation in the circles: (+) → Can feel the 5.07 filament (-) → Can't feel the 5.07 filament



Skin Conditions on the Foot or Between the Toes:

Draw in: Callous Pre-ulcer Ulcer (note length and width in cm)
Label with: R - Redness, M - Maceration, D - Dryness, T - Tinea

Risk Category:

- 0 No loss of protective sensation.
- 1 Loss of protective sensation
- 2 Loss of protective sensation with either high pressure (callous/deformity), or poor circulation.
- 3 History of plantar ulceration, neuropathic fracture (Charcot foot) or amputation.

Education done about Charcot YES Education Received

Name <u>Harris, Charles</u>	AIS NO <u>246241</u>	Date <u>01/09/07</u>	By <u>Howard, CCP</u>
-----------------------------	----------------------	----------------------	-----------------------

PRISON
HEALTH
SERVICES
INCORPORATED

FINGER STICK BLOOD RECORD FORM

NAME: Hicks, Charles

CELL SITE:

INSTITUTION/FACILITY

100

I.D. # 24624

- D.O.B

- D.O.B.: 11/2/61

PHYSICIAN ORDER/INSTRUCTIONS:

ASVS 3A + 3p X 3d

DATE	TIME	INITIALS	BLOOD SUGAR RESULTS	URINARY KETONE LEVEL (if required)	INITIALS	*	ACTIONS TAKEN/COMMENTS
3/19	1500	WT	105			*	
5/20	0400	CA	123				
5/20	1500	CA	107				
5/21	0400	CB	128				
5/21	1500	W	118				
5/22	0330	CB	102				
5/22	1500	CB	133				
5/23	0330	AB	103				
			13				
5/24	0400	CB	107				
5/24	1500	AD	133				
5/25	0400	SS	110				
5/25	1500	AD	93				
5/26	0400	CB	121				
5/26	1500	8	103				
5/27	0400	CB	117				
5/27	1500	8	134				
5/28	0400	CB	118				
5/28	0300	CB	116				
5/29	1500	WT	92				
5/29	0400	CB	105				
5/30	1500	8	117				
5/31	0900	WT	124				

*Check if results called to physician.

KIRKSON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 5/24/05

Time: _____

Facility: Kilby Correctional FacilityCheck all applicable CIC's being evaluated: Card/HTN DM GI ID PUL SZ TBSUBJECTIVE:OBJECTIVE: BP 140/100 HR 72 RR 16 Temp 98.5 Wt 260 Peak Flow _____

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ

Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

1) DM
2) HTN

no %.
Labs 5% Cok. & c (initial) 7.7
Mild urine protein. Chol 217
Hemog clean. Heart rate 72
(+ Edema (leg (chronic, familial)), (-) leg.

Maxzide 75/50 mg T.P.O. QD
ASA EC 325 mg T.P.O. QD
Glucotrol 10 mg P.O. QD
Mevacor 50 mg P.O. QD

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor

Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER
Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control
G	F	P	G	F	P	G
<input checked="" type="radio"/>	<input type="radio"/>					
I	S	W	I	S	W	I
Status	Status	Status	Status	Status	Status	Status

PLAN: 1) add ACE
2) Lwt, tach, tensity
3) Re-Ac next time
4) Re-lipids in 6 mos.

F/U: Routine 90 days: Other _____Problem List Updated: Yes No RK

Physician/NP/PA

Hicks, Charlee

NAME

male
GENDERB/W
RACE

246241

AIS#

11-2-61

DOB

DEPARTMENT OF CORRECTIONS

NURSE'S

CV/HTN CHRONIC CARE CLINIC

S: CHRONIC CARE CLINIC

DATE/TIME 5/24/06 @ 0802
 O: VS T98 P 72 R 16 WT 260
 BP 140/102

IF BP > 140/90 REFER TO MD/NP/PA

ALLERGIES

NA

HX a treadmill? Y N

Date:

HX bypass surgery: Y N

Date:

Do you smoke?

Y N

Use salt?

Y N

Family History of CVHTN?

Mother & Father

Y N

Obese?

Y N

Stress?

Y N

Blurred vision

Y N

Headache

Y N

Fatigue

Y N

Muscle weakness

Y N

Polyuria

Y N

Epistaxis

Y N

S.O.B.

Y N

Compliant with meds

Y N

KOP

Y N

Counseled on risk factors

Race - Af. Am Non-Hispanic
 Gender - M Female Male
 modifiable Heredity Non-modifiable

Modifiable Sedentary life style NA
 - smoking Cating habits (salt, fat, sugar) NA
 Labs/EKG WNL CXR if over 50 NA

P: LABS REVIEWED

Labs ordered

Last CMP-14 5/20/05

Last EKG

Education Done

Y N

Topic: Healthy lifestyle maintenance

Y N

Recently admitted to hospital/infirmiry

CURRENT MEDICATIONS:

maxzide 75/150 mg 1-2.60

mevacor 40 mg p.60

Notes:

Educational material given

Continue CHTN teaching plan

Encourage inmate to

take meds as prescribed,

& to exercise regularly

& complex C recommended

diabetic diet

Status: (circle)
IMPROVED UNCHANGED WORSENEDLevel of Control: (circle)
GOOD FAIR POORCCC WITH NURSE (circle)
1, 2, 3 MonthsCCC WITH MD (circle)
1, 2, 3, 4, 5, 6 Months

INMATE NAME	NUMBER	AGE	RACE/SEX	SIGNATURE:
Wicks, Charles	246241	44	B/M	Charles Wicks

Control Good---BP < 140/90
 Fair----BP 140-160/90/100
 Poor---BP > 160/100

Status:

Improved---BP < previous visit
 Unchanged---BP unchanged
 Worsened---BP increased,

NURSE'S
DIABETIC CHRONIC CARE CLINICS

S: DAY CHRONIC CARE CLINIC

DATE / TIME: O: VS T 98 P 72 R 14 BP 140/100 WT 240		ALLERGIES N/A	
Any reactions: Thirst, vomiting, or abdominal pain Skin or foot problems:		TYPE I <input checked="" type="checkbox"/> TYPE II <input type="checkbox"/>	
Foot exam done: Rotation of injection sites		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Changes in eyes		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Dietary compliance: Noncompliant---Education done		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	P: LABS
Medication compliant		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Noncompliant---Education done		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Last HgbA1C: Date 5/21/07 Result 7.4 %
Tremors		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Reviewed canteen list		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Compliant		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
If noncompliant, education done		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Infirmary or hospital since last CCC visit If yes, date		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	ORDERS:
Review of FLU vaccine		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Review of Pneumovax		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Fundoscopic exam		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Annual Diabetic Checklist updated		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
NOTES: Educational material given In 3 mos time A1C will 7.7% + in mate will be consistent & diet, Mod compliance to exercise			MEDICATION: Glucotrol 10 mg p.o. QD ASA/EC 325 mg p.o. QD
Education done: 1800s DP Topic FOOT / Skin Care		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Status: (circle) Improved, Unchanged, Worsened
			Control: (circle) Good, Fair, Poor
			CCC NURSE (circle) EVERY 1, 2, 3 months
			CCC WITH MD (circle) 1, 2, 3, 4, 5, 6 months
INMATE NAME Hicks, Charles	NUMBER 246241	AGE 44	RACE/SEX BSIA
Control: Good---HgbA1C WNL Fair---HgbA1C within 2 % of normal Poor---HgbA1C > 2% above normal		Status: Improved---Decrease in HgbA1C, and weight decreased by 5% Unchanged---No change in HgbA1C and weight Worsened----Increase in HgbA1C and weight	

CHRONIC CARE CLINIC
REFERRAL FORM

REFERRAL DATE: 5-19-6

REFERRING DEPT: P. E.

NAME OF PATIENT: Hicks, Charles

AIS# 246241 DOB: 11-2-61 RACE: B W

CLINIC: Dr M HTN Awka

MEDICATIONS: Mazigil 75bsg
ECA 325g
Glucotrol 10g
Mevacor 20g

COMMENTS:

DATE SEEN IN CLINIC:

Check all applicable CIC's being evaluated:

SUBJECTIVE:

Dx CHF in 1992, DM in 2002. Been on metoprolol, Lasota, Glucophage

OBJECTIVE: BP 110/80 HR 80 RR 20

Temp 98.6^o Wt 205 Peak Flow _____
NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ

Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

Mom b 79 Renal failure
DM HTN

Dad b 85 CHF, HTN

Sib = DM, CAD

Denies C/P, SOB, CHF or visual disturbances
+ pretibial edema 2+ p. Hing

S/S: dry 3 (M), & Brunfts. C/BBS diminished, & wheezing, rales on Rhonchi, Rep-ease

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor

Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER
Degree of Control						
I S W	I S W	I S W	I S W	I S W	I S W	I S W
Status						

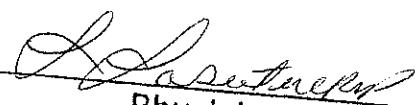
PLAN: Will place on Moxi, ASA, Glucophage, V B/P, BS. Labs, EKG, CXR, Eyes
Will give BBP 20 edema

Diet, foot care, exercise, med compliance stressed

F/U: Routine 90 days:

Other tasks

Problem List Updated: Yes No


Physician/NP/PA

Hicks, Charles
NAME

MALE
GENDER

(B) W
RACE

24624
AIS#

11-261
DOB



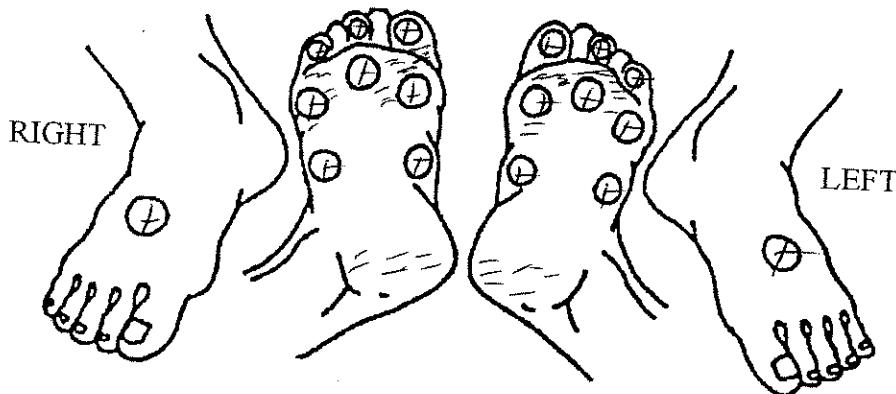
PRISON
HEALTH
SERVICES
INCORPORATED

MONOFILAMENT TESTING FOR DIABETICS

Fill in the following blanks with a "Y" or "N" to indicate findings

	RIGHT	LEFT
Is there a foot ulcer now?	Y	N
Is there a history of foot ulcer?	NY	N
Is there an abnormal shape of the foot?	N	N
Is there a toe deformity?	N	N
Are the toenails thick or ingrown?	Y	X
Is there callus buildup?	Y	Y
Is there swelling?	N	N
Is there elevated skin temperature?	Y 2+	Y 2+
Is there muscle weakness?	N	N
Can the inmate see the bottom of feet?	N	N
Is the inmate wearing improperly fitting shoes?	Y	Y
Does the inmate use footwear appropriate?	X	Y
Pulses?	Y	Y
DP/PT	2+	2+

Note the level of sensation in the circles: (+) → Can feel the 5.07 filament (-) → Can't feel the 5.07 filament



My ectatic nails
Get peeling
Multiple callous

Skin Conditions on the Foot or Between the Toes:

Draw in: Callous , Pre-ulcer , Ulcer (note length and width in cm)
Label with: R - Redness, M - Maceration, D - Dryness, T - Tinea

Risk Category:

- 0 No loss of protective sensation.
- 1 Loss of protective sensation
- 2 Loss of protective sensation with either high pressure (callous/deformity), or poor circulation.
- 3 History of plantar ulceration, neuropathic fracture (Charcot foot) or amputation.

Education done about foot care

Education Received Shautnean

Name <u>Hicks, Charles</u>	AIS NO <u>246241</u>	Date <u>11-26</u> <u>5/19/06</u>	By <u>Shautnean</u>
-------------------------------	-------------------------	--	------------------------



PRISON
HEALTH
SERVICES
INCORPORATED

DIABETIC CHECKLIST

Name Hicks, Charles Number 246241 Period 5/06 to 5/07
Medications: _____

Compliance: Yes No _____

If No, follow-up counseling done: Yes No _____ Date _____

Enrolled in Chronic Care: Yes No _____

Monofilament Foot Exams Done: Yes No _____

Foot Disorders Treated: Yes No _____

Educational Material Given: Yes No _____

Appropriate Diet Ordered: Yes No _____

Regular Glucose Testing: Yes No _____

HgbA1C done q 3 months: Yes No _____

Seen by dental at least annually: Yes No _____ Every 6 months if stable

Urine tested annually for microalbumin: Yes No _____

Seen by Nurse: Yes No _____

Seen by MD: _____

Annual dilated retinal exam: _____

Referral if necessary: _____ By: _____

Immunization: _____

Pneumococcus once and repeated after age 64, if more than 5 yrs. Yes No _____

Influenza annually Yes No _____

Annual physical exam by MD/NP Yes No _____ Date: _____

Individual treatment plan Yes No _____

Updated Yes No _____

Appropriate Diet Ordered: Yes No _____

ADOC notified: Yes No _____



DIABETIC INTAKE SCREENING
FOR INTAKES THAT PRESENT WITH DIABETES
Referral to MD and Seen within 24 hrs of Intake

NAME Hicks, Charles Number 246241 Date 5/19/06

Diagnosed with diabetes?

Yes No

If yes, then H & P by licensed health care provider with prescriptive authority.

If yes, date H & P completed 5/19/06 by L. Lassiter LP

Random plasma glucose test results 121 Date 5/19/06

If level > 200, then second test within 48 hours

Repeat results _____ Date _____

If level < 200, record flagged for a fasting glucose plasma test upon arrival at first assigned institution.

History of fasting Blood Sugar? Yes No Results/Date _____

History or Frequency of:			
Ketoacidosis	<input checked="" type="radio"/> Yes	<input type="radio"/> No	
Hypoglycemia	<input checked="" type="radio"/> Yes	<input type="radio"/> No	X 1
Hypoglycemia w/o awareness	<input checked="" type="radio"/> Yes	<input type="radio"/> No	
History of known complications	<input checked="" type="radio"/> Yes	<input type="radio"/> No	eyes, feet

Screening Laboratory Evaluation (at reception)		All diabetic receive:	
Test	Date	Results in MR	Reviewed
HgbA1c upon arrival			
HDL--Cholesterol *			
Triglycerides *			
Total Cholesterol *			
Urine for microalbumin #140050—24 hr urine			
UA for protein & ketones (onsite)			
Serum Creatinine *			
TSH (when indicated) *			
EKG (onsite)	5-19-06		
Fundoscopic Exam			
Peripheral Pulses			

* Diagnostic profile II-(048827)-Includes Chem 7, Ca++, LFT's, Lipid Panel, Fe, Phos, Total Protein, Uric acid, Globulin, Transeptidase, Thyroid Panel, CBC w/Diff

Determination of Diabetes ----circle one---- Type I Type II

Initial Treatment Plan by MD..... YES NO

Refer to Chronic Care Clinic within 7 days of

Diabetic diet..... YES NO

Education: Documented in medical record..... Date _____ YES NO

Reviewed by _____ Date _____

Name: _____

c. Current or most recent use: _____

_____d. Current Addictions: _____

e. Other:

1. In remission 6 months or less _____ 5. Drug use/denies dependency _____
 2. In remission more than one year _____ 6. Alcohol use/denies dependency _____
 3. In remission more than one year _____ 7. OBS-drug/alcohol induced _____
 4. In remission only due to incarceration _____ 8. Other: _____

IV. Emotional Statusa. No significant problems _____

_____b. Depressed _____

_____c. Anxious or stressful _____

_____d. Angry or resentful _____

_____e. Confusion or psychotic symptoms _____

_____f. Mood disturbances _____

_____g. Sexual maladjustment _____

_____History of sex offenses? Yes No List: _____h. Paranoid ideation _____

_____i. Sleep/appetite disorder _____

j. Other _____

1. Symptoms of Hypochondria _____ 4. Overtly psychotic _____ 7. Behavior disorder _____

2. Hyperactivity _____ 5. Psychosis in remission _____ 8. Senile/demented _____

3. Violent/uncontrolled _____ 6. Personality disorder _____ 9. Other _____

Name: _____

V. Mental Deficiency Mild (50-70) Moderate (35-50) Severe (20-35) Borderline (70-80) Organic impairment suspected Memory Deficit

Remarks: _____

Emotional response to incarceration: _____

VI. Mental Health

a. Outpatient treatment (dates/where) _____

b. Inpatient treatment (dates/where) _____

c. Psychotropic medication (type/effectiveness) _____

d. Family history of mental illness _____

VII. Management Problems

a. Suicide potential Ideation Yes No Plans? Yes No
 History of attempt/gestures _____

b. Serious mental illness (specify) _____

c. Impulsive/acting out behaviors predicted _____

d. Authority Conflict _____

e. Manipulative/untrustworthy _____

f. Easily victimized _____

Name: _____

g. Escape potential _____
_____h. Assaultiveness _____

i. Other: _____

1. Malingering	4. Physical handicap	7. Domestic Violence
2. Mental Deficiency	5. Self-Mutilation	8. Gender identity disorder
3. Aged and infirmed	6. Potential substance abuse in unsupervised situations	

History of expressive violence? Yes No List: _____**VIII Educational Needs**

a. ABE/GED	b. Special Education	<input checked="" type="checkbox"/> c. Trade School	d. Junior College
e. Life Skills			

IX Mental Health Needs

a. Refer to psychiatrist	e. Sexual adjustment	i. Self-concept enhancement
b. Substance abuse counseling	f. Reality therapy	j. Healthy use of leisure time
c. Depression	g. Anger management	k. Personal Development
d. Stress management	h. Values clarification	l. other _____

Recommendations/Remarks: (Include accommodations needed for the visual, hearing impaired and other disabilities) *1 on 1 A/B/C*

long list of M/W/H + Similar charges.
Individual - TTR.

During SDR and until Court Ordered.
Based on individual Trade School.

Evaluation Completed by: *WBPA* Date: *5/30/06*
 Psychologist/Psychological Associate

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

RECEPTION MENTAL HEALTH SCREENING EVALUATION

Institution: Killby Date/Time Inmate Received: 5/18/06

Date/Time of Screening: 5/18/06 Signature/Title of Screener: D. McLeod, Lpn

MENTAL HEALTH TREATMENT PRIOR TO ENTERING THE ADOC:

Yes No Psychotropic medication: _____

Yes No Medication turned over to ADOC upon arrival? _____

Yes No Mental health follow-up in last 90 days: _____

Yes No Suicide/self-harm attempts in last 90 days: _____

MENTAL HEALTH HISTORY Does inmate report a history of the following (if yes, provide details):

Yes No Outpatient treatment: _____

Yes No Inpatient treatment: _____

Yes No Psychotropic medication: _____

Yes No Suicidal attempts: _____

Yes No Suicidal thoughts: _____

Yes No Head injury: _____

Yes No Seizures: _____

Yes No Violent behavior: _____

Yes No Substance abuse: Eth

Yes No Substance abuse treatment: _____

Yes No Special education classes: _____

INMATE SELF-REPORT OF CURRENT STATUS:

Yes No First incarceration (reaction): "disappointed"

Yes No Reports family support: Aunt

Yes No Reports significant depression/remorse: _____

Yes No Thinking about suicide: _____

Yes No Has plan for suicide: _____

Yes No Possible to implement suicide plan: _____

Yes No Reports hallucinations: _____

BEHAVIORAL OBSERVATIONS:

Poor eye contact	Poor hygiene	Unable to pay attention	Unresponsive
Disoriented	Anxious	Unable to follow directions	Unable to read
Crying	Memory deficits	Signs of self-mutilation	Afraid
Illogical speech content	Appears to be hearing voices or seeing things		Paranoid
Hostile	Other unusual behavior:		

DISPOSITION/PLACEMENT RECOMMENDATION (based on reception mental health screening):

Routine housing

Emergency mental health referral

Mental health follow-up but not emergency

Crisis cell placement recommended

Current psychotropic meds verified

Interim supply ordered

Inmate Name: Hicks, Charles

AIS #: 246241

Disposition: Inmate Medical Record

Reference: ADOC AR 610, 612, 635
ADOC Form MH-011 - November 14, 2005

ALABAMA DEPARTMENT OF CORRECTIONS
INMATE ORIENTATION TO MENTAL HEALTH SERVICES

The Alabama Department of Corrections provides the following mental health services:

- Assessment and treatment of mental illness
- Referral to a psychiatrist, if necessary for medication
- On-going psychiatric treatment
- Group and individual counseling
- Assistance in dealing with stressful problems (adjustment to prisons, grief and loss, family problems)
- Crisis intervention
- Residential mental health treatment and hospitalization, if necessary

If you wish to speak with mental health staff about routine matters such as scheduling for group or individual counseling, send in a Health Services Request form.

In emergency situations or if you have concerns that need to be addressed immediately, contact any correctional officer so that you may receive mental health assistance as soon as possible.

Your participation in mental health services is voluntary except in emergency situations or when you have been provided due process through administrative review.

If you believe the mental health services provided to you are inadequate, you may file an inmate grievance.

Information about the mental health services provided to you is confidential except in the situations when mental health staff believe that you may be:

- Suicidal
- Homicidal
- Presenting a clear danger of injury to self or others
- Presenting a reasonable clear risk of escape or creation of institutional disorder
- Receiving Psychotropic medication
- Requiring movement to a special unit or cell for observation and treatment
- Requiring transfer to a psychiatric hospital outside of the prison
- Requiring a new program assignment for mental health reasons

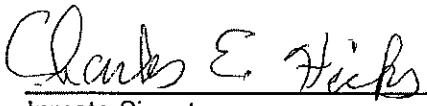
Mental health staff has a legal duty to report to appropriate authorities any unreported suspected abuse or neglect of a child.

Mental health and medical staff will have access your mental health records when completing their duties. The following persons may have access to your mental health records on a need to know basis:

- Warden of the institution or designee
- Internal investigation staff and legal counsel working with the ADOC
- Departmental and accrediting audit staff
- Persons authorized by a court order or judgment

All other persons or agencies require an authorization for release of information signed by you before gaining access to your mental health records.

This information on this form has been explained to me and I have received a copy of the information for my future reference.


Inmate Signature

246241
AIS #

Date Signed



BLOOD SUGAR

NAME: Hicks, Charles

AJS并

246249

SITE:

FLYC

Prison Health Services

REFUSAL OF TREATMENT FORM

Institution: ELLYCResident's Name: Charles Hicks ID# _____D.O.B. 11-2-61I, Charles Hicks
(Name of Inmate)

have, this day, knowing that I have a condition

requiring medical care as indicated below:

 A. Refused medication. E. Refused X-Ray services. B. Refused dental care. F. Refused other diagnostic tests. C. Refused an outside medical appointment. G. Refused physical examination. D. Refused laboratory services H. Other (Please specify)

Reason For Refusal

No need to be screened

Potential Consequences Explained

I acknowledge that I have been fully informed of and understand the above treatment recommendations and the risks involved in refusing them. I hereby release and agree to hold harmless the state, statutory authority, all correctional personnel, medical/health personnel from all responsibility and any ill effects which may result from this refusal and I shall personally assume responsibility for my welfare.

I have read this form and certify that I understand its contents.

J. Surindell Jr
Witness SignatureJ. Osborne, COI
Witness Signature11-8-06
DateCharles Hicks
Patient Signature11 55/AM
Time

NOTE: A refusal by the resident to sign requires the signatures of at least one witness in addition to that of the medical staff member.



SPECIAL NEEDS COMMUNICATION FORM

Date: 11/3/06To: FLYCFrom: Station HuInmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Bottom Pwink profile x 180 Days Stop 5/3/07

No Prolonged Standing

Start 11/3/06

Front of line

Walking cane

x 180 days

Anti Embolism Stockings

Stop 11/3/06

Date: 11/3/06 MD Signature: Williams Time: _____



DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Hicks, Charles
(Print Name)

246241

(Doc#)

acknowledge receipt of the following medical equipment or appliance:

- Splint
- Eyeglasses
- Dentures
- Prosthesis describe _____
- Wheelchair
- Cane
- Crutches
- Other describe Antembolic stocking x

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Charles Hicks
(Inmate)

11/3/06

(Date)

(Witness)

(Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
<u>Hicks, Charles</u>	<u>246241</u>	<u>11/12/61</u>		



SPECIAL NEEDS COMMUNICATION FORM

Date: 10-27-06

To: DOC

From: Staton HCU

Inmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Slide Profile → Marked
peripheral edema x 60 days

 A hand-drawn graph on a lined page. It consists of several peaks and troughs, representing a slide profile. The peaks are labeled with the text 'x 60 days' written vertically next to them. The graph is drawn with a single continuous line.

Date: 10-28-06 MD Signature: A. Blum / Dr. Corbier Time: 9:00 pm

Treatment Continued:

Epsom Salt Soaks QD x 14 days

BP Vs QD x 14 days

Date	Date	Date	Date	Date	Date	Date
10/8	10/9	10/10	10/11	10/12	10/13	10/14
		Done 142/100	Done 140/85		Done	Done 148/90
		MS	MS	Yones M	MS	MS
Initials	Initials	Initials	Initials	Initials	Initials	Initials

| Date |
|----------|----------|----------|----------|----------|----------|----------|
| 10/15 | 10/16 | 10/17 | 10/18 | 10/19 | 10/20 | 10/21 |
| | 118/16 | 120/80 | 112/85 | | 140/90 | |
| | MS | | | | NB | |
| Initials |

Date	Date	Date	Date	Date	Date	Date
10/22						
150/88						
TX Done						
NB						

Comments:

Patient Name/Number	Allergies:	Housing Unit:
Hicks, Charles	NKA	F2/C



SPECIAL NEEDS COMMUNICATION FORM

Date: 10/24/06To: F/ycFrom: HCCInmate Name: Hicks, Charles ID#: 246241**The following action is recommended for medical reasons:**

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:Blood Sugar Checks x 2 weeks to expire 11/4/06Date: 10/24/06 MD Signature: WON Dr Paul J. McRae Jr Time: 1915

Treatment Continued:

6/P ✓ qd x 14 days

| Date |
|---------|---------|---------|---------|---------|---------|---------|
| 9/13/00 | 9/14/00 | 9/15/00 | 9/16/00 | 9/17/00 | 9/18/00 | 9/19/00 |
| 130/90 | 146/98 | N | N | 124/88 | 126/80 | 150/96 |
| MHS |

pm

| Date |
|---------|---------|---------|---------|---------|---------|---------|
| 9/20/00 | 9/21/00 | 9/22/00 | 9/23/00 | 9/24/00 | 9/25/00 | 9/26/00 |
| 166/96 | 144/88 | | 122/80 | | | 150/99 |
| MHS | MHS | | MHS | | MHS | |

pm

| Date |
|------|------|------|------|------|------|------|
| | | | | | | |
| | | | | | | |
| | | | | | | |

Comments:

Patient Name/Number 246241 Hick, Charles	Allergies: NKDA	Housing Unit: FLYC
--	--------------------	-----------------------



SPECIAL NEEDS COMMUNICATION FORM

PRISON
HEALTH
SERVICES
INCORPORATEDDate: 10-2-06To: F4CFrom: SHCUInmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

2000 CAL ADA diet x 180 daysMay purchase diabetic shoes off store Date: 10/2/06 MD Signature: Mahood, CRNP J. Park, LPN Time: 10:42 pm

BLOOD SUGAR

e 38 of 64
7/5/86 → 8/5

2. SITE: Hicks, Charles

AIS#: 246241

SITE: FLY



MEDICAL INFORMATION TRANSFER FORM

Confidential Medical Data

To: Jefferson Co. Det.

(Agency)

Inmate's Name: Hicks, Charlie

(Address)

a/k/a:

D.O.B.: 11/2/61 SS #: 420-90-638From: FDC

Person Completing Form

(Institution)

Name: An Officer, LPN(Address): (334) 567-1548Signature: Clayton

(Telephone)

Date: 3/6/06

MEDICAL PROBLEM(S):

HTN
DM II

TREATMENTS/MEDICATIONS:

Mexalide 75mg po qd
E ASA 325mg po qd
Gluctrol 10mg po qd
Metformin 250mg po qd
U Simopen 200mg po qd

Allergies: NA

TB Skin Test:	NEG	POS	Date <u>3/6/06</u>
CXR:	NEG	POS	Date _____

Pregnant: Yes _____ No _____ Unknown _____

Test	Treated	Date
RPR: NEG	POS	Yes No
VDRL: NEG	POS	Yes No
GC: NEG	POS	Yes No
Other: _____	Yes No	_____

Other Lab Data:



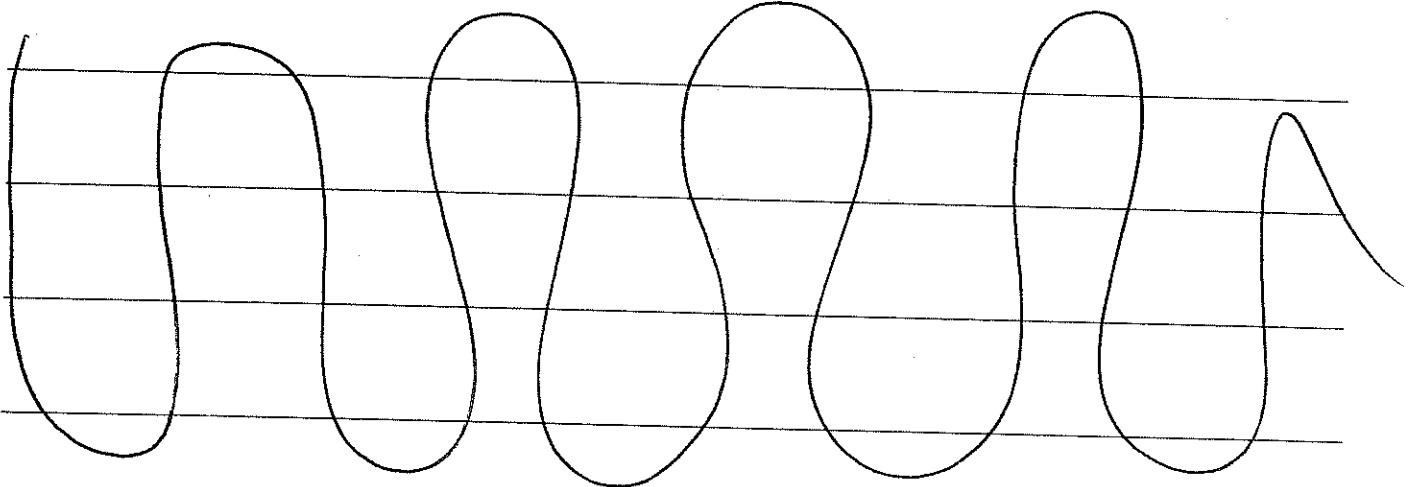
SPECIAL NEEDS COMMUNICATION FORM

Date: 7-12-08To: Frank LeeFrom: HCUInmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other Start 2000 cal ADA diet x 365 days

Comments:

Date: 7-12-08 MD Signature: Dr. Pleasant / S. Taylor RN Time: 10:110AM



DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Hicks Charles
(Print Name)

246241
(Doc#)

acknowledge receipt of the following medical equipment or appliance:

- Splint
- Eyeglasses
- Dentures
- Prothesis
- Wheelchair
- Cane
- Crutches
- Other

describe Thigh Length TED Hose

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Charles Hicks

(Inmate)

7-5-06

(Date)

Al Hall Smith Jr

(Witness)

7/5/06

(Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
<u>Hicks, Charles</u>	<u>246241</u>	<u>11/02/61</u>	<u>B1m</u>	<u>PLYC</u>



7

5/28/06

BLOOD PRESSURE RECORD

INSTRUCTIONS:

PHYSICIAN:

NAME: Hicks, Charles

LOCATION: _____

246241

PHS
PRISON
HEALTH
SERVICES
INCORPORATED

Date: 7/5/06

To: FLYC

From: S Hec

Inmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in
2. Medical Isolation
3. Work restrictions
4. May have extra _____ until _____
5. Other _____

Comments:

Blood Sugar Checks 3A + 3P X 30 Days

Start 7/5/06
Stop 8/5/06

Date: 7/6/06 MD Signature: Howard J. Gordon Time: _____



SPECIAL NEEDS COMMUNICATION FORM

Date: 5-19-06

To: ADOC

From: Phyp

Inmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra Extra Blanket to allow inmate to 7 feet X 3 months.
5. Other _____

Comments:

Bottom Bunk profile X 3 months

Trim nails @ TX Time - notify provider to do.

AFC Bid x 30 day AAA thin layer

AFD ant. AAA Bid x 30 d.

Date: 5/19/06 MD Signature: Hasater / pgj Time: 10:00

(H)
Prison Health Services
Treatment Record

Treatment Ordered:

Trim nails TX. Time - Call
Provider to clip nails

| Date |
|----------|----------|----------|----------|----------|----------|----------|
| | | | | | | |
| | | | | | | |
| Initials |
| Date |
| | | | | | | |
| | | | | | | |
| Initials |

Comments:

Patient Name/Number Hicks, Charles 2460241	Allergies: NCDA	Housing Unit: S-60 E-Down M-7H
--	--------------------	---

Frank Lee Youth Center

Sick call is performed at 4:00 am (after pill call) in the shift office Monday through Friday. All completed sick call requests and grievances must be given to evening pill call nurse. All sick call requests must be completed and turned by 2:30 pm daily.

Pill call is performed twice a day from the shift office at the times stated below. Pill call is subject to change by health care unit and security.

1. Morning pill call: 3:00 am
2. Noon pill call: None
3. Evening pill call: 4:00 pm

Any dental, medical, or mental health educational information can be obtained through a written request to the Health Services Administrator.

I have had the opportunity to ask questions concerning the above information, and I have received a copy.

Inmate Signature: Charles Hicks

Date: 6-17-06

Nurse Signature: C. Hulcham

Date: 6/18/06

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT)

HICKS

LAST

Charles

FIRST

MI

DATE OF BIRTH

11-2-61

SS# 420-90-0383

Housing Recommendations:

General Population Medical Observation Unit Lower Level/Lower Bunk Suicide Precautions Special Watch (15 Minute Checks) Isolation Initiate Universal Precautions

Individual found to be:

Frail/Elderly Physically Handicapped Developmentally Disabled Drug/Alcohol Withdrawal Special Mental Health Needs Expressed Suicidal Ideation History of Seizures Other

Specify _____

Nurse

C. Hellier

Date

6/18/06

CC
HTN
XDM II*



FAX (334) 215-9126
Phone (334) 215-6628

DEPARTMENT OF CORRECTIONS

AUTHORIZATION FOR RELEASE OF INFORMATION

To: Cooper Green Hosp.
Birmingham Al.

From: PHS of Kilby Prison
P.O. Box 11
Mt. Meigs, Al
36057

Patient: Hicks, Charles

Inmate ID No.: 246241

Alias: _____

Social Security No.: 420-90-0383

Date of Birth: 11-2-61

Date(s) of Service: 2005 May

I hereby authorize the above named provider to release to Prison Health Services, Inc. and Kansas Department of Corrections the following confidential information:

<input checked="" type="checkbox"/> Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care	<input checked="" type="checkbox"/> Discharge	<input checked="" type="checkbox"/> Operative Summary Reports
<input checked="" type="checkbox"/> Admission	<input type="checkbox"/> Special Studies Reports	<input type="checkbox"/> HIV Test
<input checked="" type="checkbox"/> X-Ray	<input type="checkbox"/> Immunization History	<input type="checkbox"/> Dental Treatment Records
<input checked="" type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Drug Treatment History & Counseling Reports	
<input type="checkbox"/> Psychiatric Summary Report		
<input checked="" type="checkbox"/> Other Records <u>Cardiac / DM</u>		

(Specify information requested)

This authorization shall remain in full force and effect until withdrawn in writing by me. I hereby release and agree to hold provider harmless from any and all liability that may result from such release of information.

Charles Hicks
(Patient's Signature)

5-19-06

(Date)

Rhj
(Witness' Signature)

5-19-06

(Date)

The information requested is recognized as confidential and will be used only to ensure prompt and appropriate treatment of the named patient.

Charlotte Jost
(Signature and Title for PHS)

5-19-06

(Date)



PRISON
HEALTH
SERVICES
INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 5/18/06

To: Adoc

From: Wu

Inmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

B5 vs Daily 3A + 3P X 38 days.

W

Date: 5/18/06 MD Signature: Protocol/Robbins Time: 16:00

Wednesday

60418



PRISON
HEALTH
SERVICES
INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 5/19/06

To: _____

From: _____

Inmate Name: Hicks Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

B/P v/s on Monday & Wed
at 0500 am on Westward X

4wks

Date: 5/19/06 MD Signature: WO, L Lassiter NP/ Time: 915

W. Stough Jr.

60418

RECEIVING SCREENING FORM

INMATE'S NAME: Hicks, Charles DATE: 5/18/06 TIME: 10³⁰
 DOB: 11-2-61 OFFICER: COI Hives INSTITUTION: KILBY

RECEIVING OFFICER'S VISUAL OPINION

	YES	NO
Is the inmate conscious?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is the skin in poor condition or show signs of vermin or rashes?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does the inmate appear to be under the influence of alcohol, or drugs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is the inmate making any verbal threats to staff or other inmates?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does the inmate have any obvious physical handicaps?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

FOR THE OFFICER

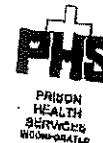
Was the new inmate oriented on sick/dental call procedures?

This inmate was

a. Released for normal processing
 b. Referred to health care unit
 c. Immediately sent to the health care unit.

Col Hives
 Officer's Signature

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards.



200
93D
FAX (384) 215-9126
Phone (384) 215-6672

DEPARTMENT OF CORRECTIONS

AUTHORIZATION FOR RELEASE OF INFORMATION

To: Cooper Green Hosp.
Birmingham Al.

From: PHS @ Kelly Prison
P.O. Box 4
Mt. Meigs, Al
36007

Patient: Hicks, Charles.

Inmate ID No.: 246241

Alias: _____

Social Security No.: 420-90-0383

Date of Birth: 11-2-61

Date(s) of Service: 2005 May

I hereby authorize the above named provider to release to Prison Health Services, Inc. and Kansas Department of Corrections the following confidential information:

Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care 336334

Admission

Discharge

X-Ray

Special Studies Reports

Laboratory Reports

Immunization History

Psychiatric Summary Report

Drug Treatment History & Counseling Reports

Other Records: Cardiac DM

Operative Summary Reports

HIV Test

Dental Treatment Records

(Specify information requested)

This authorization shall remain in full force and effect until withdrawn in writing by me. I hereby release and agree to hold provider harmless from any and all liability that may result from such release of information.

Charles Hicks

(Patient's Signature)

5-19-06

(Date)

Rhy

(Witness' Signature)

5-19-06

(Date)

The information requested is recognized as confidential and will be used only to ensure prompt and appropriate treatment of the named patient.

Charles J. Foster

(Signature and Title for PHS)

5-19-06

(Date)

Case 2007-00990-MEF-CSC
COOPER GREEN HOSPITAL
EMERGENCY DEPARTMENT RECORD
EMERGENCY SERVICES CARE PROTOCOLS

TIME _____

DATE _____

CHEST PAIN <ul style="list-style-type: none"> OLD CHART, CARDIAC MONITOR, SALINE LOCK STAT ECG <input type="checkbox"/> CBC, CMP, CHEST PAIN PANEL, MG, PCXR • PULSE OXIMETRY <input type="checkbox"/> O2 per _____ <input type="checkbox"/> UDS • UCG IF INDICATED • ASPIRIN 81MG TO CHEW IF NO ALLERGY <input type="checkbox"/> NITROGLYCERIN 0.4 MG SL Q 5 MIN (IF SBP > 90) <input type="checkbox"/> LABETOLOL 5 MG IV (IF SBP > 90) 		
BRAIN ATTACK/ ALTERED MENTAL STATUS <ul style="list-style-type: none"> OLD CHART, CARDIAC MONITOR, SALINE LOCK, ECG, ACCUCHECK <input type="checkbox"/> CBC, CMP, PT/PTT, T4, TSH, B12, U/A, PCXR • PULSE OXIMETRY <input type="checkbox"/> O2 per _____ <input type="checkbox"/> BRAIN CT <input type="checkbox"/> UDS • UCG IF INDICATED 		
SUSPECTED OVERDOSE <ul style="list-style-type: none"> OLD CHART, CARDIAC MONITOR, SALINE LOCK, ECG, ACCUCHECK <input type="checkbox"/> CBC, CMP, ACETAMINOPHEN & SALICYLATE LEVEL <input type="checkbox"/> ETOH LEVEL IF INDICATED • PULSE OXIMETRY <input type="checkbox"/> O2 per _____ <input type="checkbox"/> UDS • UCG IF INDICATED 		
SOB/RESPIRATORY DISTRESS <ul style="list-style-type: none"> OLD CHART, CARDIAC MONITOR, SALINE LOCK <input type="checkbox"/> CBC, CMP, ABC (IF SAT < 90) • UCG IF INDICATED • PULSE OXIMETRY (O2 IF SAT < 90) <input type="checkbox"/> O2 per _____ <input type="checkbox"/> ALBUTEROL/ATROVENT NEBS Q 15 MIN X'S 3 <input type="checkbox"/> ECG <input type="checkbox"/> SOLUMEDROL 125 MG IV <input type="checkbox"/> BLOOD CULTURES X 2 BEFORE ANTIBIOTICS (IF TEMP > 100.6) <input type="checkbox"/> ROCEPHMIN 1 GM IV <input type="checkbox"/> LEVAQUIN 500MG IV 		
ETOH INTOXICATION <ul style="list-style-type: none"> OLD CHART, SALINE LOCK <input type="checkbox"/> CBC, CMP, ETOH, MG, ACCUCHECK <input type="checkbox"/> IV FLUIDS WITH 1 AMP MVI, FOLATE, THIAMINE 100MG • PULSE OXIMETRY (O2 IF SAT < 90) <input type="checkbox"/> O2 per _____ <input type="checkbox"/> UDS IF INDICATED • UCG IF INDICATED 		
GI BLEED <ul style="list-style-type: none"> OLD CHART, CARDIAC MONITOR <input type="checkbox"/> CBC, CMP, PT/PTT, U/A, PCXR <input type="checkbox"/> TYPE AND SCREEN IF INDICATED • UCG IF INDICATED <input type="checkbox"/> IV FLUIDS NS @ _____ ML/HR <input type="checkbox"/> NG TUBE IF INDICATED <input type="checkbox"/> HEMOCULT STOOLS <input type="checkbox"/> ABDOMINAL SERIES 		
NEW ONSET SEIZURE <ul style="list-style-type: none"> OLD CHART, CARDIAC MONITOR, SALINE LOCK <input type="checkbox"/> CBC, BMP, CA, MG, ACCUCHECK <input type="checkbox"/> UDS IF INDICATED <input type="checkbox"/> ETOH IF INDICATED • UCG IF INDICATED • PULSE OXIMETRY (O2 IF SAT < 90) <input type="checkbox"/> O2 per _____ <input type="checkbox"/> BRAIN CT <input type="checkbox"/> ATIVAN 2 MG FOR ACTIVE SEIZURES 		
SICKLE CELL CRISIS <ul style="list-style-type: none"> OLD CHART, CARDIAC MONITOR, SALINE LOCK, PCXR <input type="checkbox"/> IV FLUIDS NS @ _____ ML/HR <input type="checkbox"/> CBC, RETICULOCYTE COUNT, CMP, UA • UCG IF INDICATED • PULSE OXIMETRY (O2 IF SAT < 90) <input type="checkbox"/> O2 per _____ <input type="checkbox"/> DILAUDID 2 MG IV 		
FEVER > 100.6 IMMUNOCOMPROMISED/ AGE 60 OR OLDER <ul style="list-style-type: none"> OLD CHART, SALINE LOCK, PCXR <input type="checkbox"/> CBC, CMP, UA, URINE C & S <input type="checkbox"/> BLOOD CULTURES X 2 BEFORE ANTIBIOTICS (IF TEMP > 100.6) • UCG IF INDICATED • PULSE OXIMETRY (O2 IF SAT < 90) <input type="checkbox"/> O2 per _____ • ACETAMINOPHEN 650 MG PO OR RECTAL PRN FOR TEMP > 100.6 		
SUSPECTED RENAL COLIC <ul style="list-style-type: none"> OLD CHART, SALINE LOCK <input type="checkbox"/> CBC, CMP, UA <input type="checkbox"/> ABDOMINAL SERIES • UCG IF INDICATED 		
SUSPECTED PYLONEPHRITIS <ul style="list-style-type: none"> OLD CHART, SALINE LOCK <input type="checkbox"/> CBC, CMP, UA, URINE, C & S • UCG IF INDICATED • ACETAMINOPHEN 650 MG PO OR RECTAL PRN FOR TEMP > 100.6 		
LOWER ABD PAIN/ VAGINAL BLEEDING <ul style="list-style-type: none"> OLD CHART, SALINE LOCK <input type="checkbox"/> CBC, CMP, UA • UCG IF INDICATED <input type="checkbox"/> SERUM QUANT. HCG IF UCG POSITIVE <input type="checkbox"/> TYPE & RH IF PREGNANT AND BLEEDING <input type="checkbox"/> ABDOMINAL SERIES • ACETAMINOPHEN 650 MG PO OR RECTAL PRN FOR TEMP > 100.6 		
EXTREMITY INJURY <p>SALINE LOCK IMMOBILIZE/ELEVATE EXTREMITY APPLY COLD COMPRESS IF INJURY < 48 HRS OLD TETANUS TOXOID, 0.5 ML IM IF INDICATED X-RAY _____ ICG IF INDICATED</p>		
SUSPECTED HIP FRACTURE <ul style="list-style-type: none"> SALINE LOCK <input type="checkbox"/> CBC, CMP, UA <input type="checkbox"/> X-RAY <input type="checkbox"/> R HIP <input type="checkbox"/> L HIP <input type="checkbox"/> X-RAY _____ • UCG IF INDICATED 		
LACERATIONS <ul style="list-style-type: none"> <input type="checkbox"/> CLEAN WOUND WITH SALINE <input type="checkbox"/> X-RAY IF FOREIGN BODY/PRACTURE SUSPECTED <input type="checkbox"/> X-RAY _____ <input type="checkbox"/> TETANUS TOXOID, 0.5 ML IM IF INDICATED • SUTURE SET-UP 		
MEDICAL CLEARANCE FOR PSYCHIATRIC EVALUATION <p>BC, BMP TOH DS ICG IF INDICATED</p>		
THERAPEUTIC LEVELS WHEN INDICATED <ul style="list-style-type: none"> <input type="checkbox"/> DIGOXIN <input type="checkbox"/> THEOPHYLLINE <input type="checkbox"/> DILANTIN <input type="checkbox"/> PHENOBARBITAL <input type="checkbox"/> PROTIME (PT) / INR 		
<p>MD SIGNATURE _____ RN SIGNATURE _____ CLERK'S SIGNATURE _____</p> <ul style="list-style-type: none"> • Done without MD order • Requires Physician order 		

JEFERSON HEALTH SYSTEM
COOPER GREEN HOSPITAL
EMERGENCY DEPARTMENT RECORD

Level 1, 2, 3 Documentation - 1 to 3 elements

All elements not circled/striked/checked/annotated - were not pertinent

Level 4 - 4 to 8 elements or 3 chronic or inactive conditions

Level 5 - 9 elements or 3 chronic or inactive conditions

Time seen
by physician

120

Chief complaint: incarcerated for 1monh, out of med/s 1 week.
 C/o legs swelling more in (L) leg. Denies any SOB or chest pain.
 Really just feels up. w/ to get PMD to follow

Physician CC & History of Present Illness

 Symptom/Location Severity Modifying Factors Context/Mechanism of Injury Quality Duration Timing Associated Signs & Sx EMS Direction

Level 1, 2, 3 Documentation - 1 system, problem pertinent

 All systems negative except as noted Unable to fully assess due to:

() altered LOC () patient condition () other

Pain Severity 0 - 1 - 2 - 3 - 4 - 5 (Circle One)

Level 1, 2, 3 Documentation - 10+ systems

change MS agitation sedation

confusion depression hostility

memory loss

fatigue polyuria hair change

weakness polydipex heat tolerance

bruising nodes

bruising petechiae

rhinitis atopic dermat.

asthma sneezing

itchy eyes

rash hives

bruising contusions

swelling lacerations abrasions

bruising nodes

bruising petechiae

rhinitis atopic dermat.

asthma sneezing

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asthma sneezing

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bruising contusions

swelling lacerations abrasions

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swelling lacerations abrasions

bruising nodes

bruising petechiae

rhinitis atopic dermat.

asthma sneezing

itchy eyes

rash hives

bruising contusions

swelling lacerations abrasions

bruising nodes

bruising petechiae

rhinitis atopic dermat.

asthma sneezing

itchy eyes

rash hives

bruising contusions

swelling lacerations abrasions

bruising nodes

bruising petechiae

rhinitis atopic dermat.

asthma sneezing

itchy eyes

rash hives

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itchy eyes

rash hives

bruising contusions

swelling lacerations abrasions

bruising nodes

JEFFERSON HEALTH SYSTEM
 COOPER GREEN HOSPITAL
 EMERGENCY DEPARTMENT RECORD

Date

1/18/04

HICKS, CHARLES
 00-33-63-34 09102004
 DOUTON, HUGUETTE
 X 42 11/02/61 S

Name Charles E. Hicks

Primary Diagnosis (4, M62.836585) 33

Vital Signs BP / Pulse / Resp / Temp /

Allergies NKA

Time Ordered

MED / FLUID / DOSE / ROUTE / RATE

8:30

BD

1831

BD

CBC BMP 1835

2015 AM

2015 AM

2015 AM

THERAPEUTIC

Consultation: Dr: _____ Called _____ Ans _____ Arr _____ Dr: _____ Called _____ Ans _____ Arr _____

Initial Impression/Different Diagnosis _____

Additional history, exam, reassessments _____

Secondary Diagnosis _____ Secondary Diagnosis _____

Secondary Diagnosis _____ Secondary Diagnosis _____

CONDITION

DISPOSITION

Stable Improved Deteriorating Exp. AMA DC Admit IP OB Transfer to _____

Notification: Family Police Coroner Time _____ By _____

CERTIFIED MEDICAL EMERGENCY

 YES NO

Physician
 Signature
 Chart complete when checked

NOTE
 DICTATED

COOPER GREEN HOSPITAL
EMERGENCY DEPARTMENT RECORD
EMERGENCY SERVICES CARE PROTOCOLS

HICKS, CHARLES
00-33-63-34

DOUYN, HUGUETTE
42 11/02/61 S

09/02/2004

keyplate

TIME _____

DATE / /

26836585

33

CHEST PAIN

- OLD CHART, CARDIAC MONITOR, SALINE LOCK
- STAT ECG
- CBC, CMP, CHEST PAIN PANEL, MG, PCXR
- PULSE OXIMETRY
- O2 per _____
- UDS
- UCG IF INDICATED
- ASPIRIN 81MG TO CHEW IF NO ALLERGY
- NITROGLYCERIN 0.4 MG SL Q 5 MIN (IF SBP > 90)
- LABETOLOL 5 MG IV (IF SBP > 90)

BRAIN ATTACK/
ALTERED MENTAL STATUS

- OLD CHART, CARDIAC MONITOR, SALINE LOCK, ECG, ACCUCHECK
- CBC, CMP, PT/PTT, T4, TSH, B12, U/A, PCXR
- PULSE OXIMETRY
- O2 per _____
- BRAIN CT
- UDS
- UCG IF INDICATED

SUSPECTED OVERDOSE

- OLD CHART, CARDIAC MONITOR, SALINE LOCK, ECG, ACCUCHECK
- CBC, CMP, ACETAMINOPHEN & SALICYLATE LEVEL
- ETOH LEVEL IF INDICATED
- PULSE OXIMETRY
- O2 per _____
- UDS
- UCG IF INDICATED

SOB/RESPIRATORY DISTRESS

- OLD CHART, CARDIAC MONITOR, SALINE LOCK
- CBC, CMP, ABG (IF SAT < 90)
- UCG IF INDICATED
- PULSE OXIMETRY (O2 IF SAT < 90)
O2 per _____
- ALBUTEROL/ATROVENT NEBS Q 15 MIN X'S 3
- ECG
- SOLUMEDROL 125 MG IV
- BLOOD CULTURES X 2 BEFORE ANTIBIOTICS (IF TEMP > 100.6)
- ROCEPHIN 1 GM IV
- LEVAQUIN 500MG IV

ETOH INTOXICATION

- OLD CHART, SALINE LOCK
- CBC, CMP, ETOH, MG, ACCUCHECK
- IV FLUIDS WITH 1 AMP MVI, FOLATE THIAMINE 50MG
- PULSE OXIMETRY (O2 IF SAT < 90)
O2 per _____
- UDS IF INDICATED
- UCG IF INDICATED

GI BLEED

- OLD CHART, CARDIAC MONITOR
- CBC, CMP, PT/PTT, U/A, PCXR
- TYPE AND SCREEN IF INDICATED
- UCG IF INDICATED
- IV FLUIDS NS @ _____ ML/HR
- NG TUBE IF INDICATED
- HEMOCULT/STOOLS
- ABDOMINAL SERIES

NEW ONSET SEIZURE

- OLD CHART, CARDIAC MONITOR, SALINE LOCK
- CBC, BMP, CA, MG, ACCUCHECK
- UDS IF INDICATED
- ETOH IF INDICATED
- UCG IF INDICATED
- PULSE OXIMETRY (O2 IF SAT < 90)
O2 per _____
- BRAIN CT
- ATIVAN 2 MG FOR ACTIVE SEIZURES

RESPIRATORY PRECAUTIONS

- OLD CHART, CARDIAC MONITOR, SALINE LOCK, ECG
- IV FLUIDS NS @ _____ ML/HR
- CBC, RETICULOCYTE COUNT, CMP, UA
- UCG IF INDICATED
- PULSE OXIMETRY (O2 IF SAT < 90)
O2 per _____
- DILALDID 2 MG IV

FEVER > 100.6 IMMUNOCOMPROMISED/
AGE 60 OR OLDER

- OLD CHART, SALINE LOCK, PCXR
- CBC, CMP, UA, URINE C & S
- BLOOD CULTURES X 2 BEFORE ANTIBIOTICS (IF TEMP > 100.6)
- UCG IF INDICATED
- PULSE OXIMETRY (O2 IF SAT < 90)
O2 per _____
- ACETAMINOPHEN 650 MG PO OR RECTAL PRN FOR TEMP > 100.6

SUSPECTED RENAL COLIC

- OLD CHART, SALINE LOCK
- CBC, CMP, UA
- ABDOMINAL SERIES
- UCG IF INDICATED

- OLD CHART, SALINE LOCK
- CBC, CMP, UA, URINE, C & S
- UCG IF INDICATED
- ACETAMINOPHEN 650 MG PO OR RECTAL PRN FOR TEMP > 100.6

LOWER ABD PAIN/
VAGINAL BLEEDING

- OLD CHART, SALINE LOCK
- CBC, CMP, UA
- UCG IF INDICATED
- SERUM QUANT. HCG IF UCG POSITIVE
- TYPE & RH IF PREGNANT AND BLEEDING
- ABDOMINAL SERIES
- ACETAMINOPHEN 650 MG PO OR RECTAL PRN FOR TEMP > 100.6

EXTREMITY INJURY

- SALINE LOCK
- IMMOBILIZE/ELEVATE EXTREMITY
- APPLY COLD COMPRESS IF INJURY < 48 HRS OLD
- TETANUS TOXOID, 0.5 ML IM IF INDICATED
- X-RAY
- UCG IF INDICATED

SUSPECTED HIP FRACTURE

- SALINE LOCK
- CBC, CMP, UA
- X-RAY R HIP L HIP
- X-RAY
- UCG IF INDICATED

LACERATIONS

- CLEAN WOUND WITH SALINE
- X-RAY IF FOREIGN BODY/FRACTURE SUSPECTED
- X-RAY
- TETANUS TOXOID, 0.5 ML IM IF INDICATED
- SUTURE SETUP

MEDICAL CLEARANCE FOR
PSYCHIATRIC EVALUATION

- CBC, BMP
- ETOH
- UDS
- UCG IF INDICATED

- DIGOXIN
- THEOPHYLLINE
- DILANTIN
- PHENOBARBITAL
- PROTIME (PT) / INR

MD SIGNATURE _____

RN SIGNATURE _____

CLERK'S SIGNATURE _____

- Done without MD order
- Requires Physician order

JEFFERSON HEALTH SYSTEM
COOPER GREEN HOSPITAL
EMERGENCY DEPARTMENT RECORD

HICKS, CHARLES
00-33-63-34
DOUYN, HUGUETTE
8 42 11/02/61 8
102004

26836585

33

Level 1, 2, 3 Documentation - 1 to 3 elements

All elements not circled/struck/checked/annotated - were not pertinent
Level 4 - 4 > elements or 3 chronic or inactive conditions

Level 5 > 5 elements or 3 chronic or inactive conditions

Time seen
by physician

Chief complaint:

The pt presents today for my soffers.
Patient w/o any of his meds x 7 years.
He denies any other symptoms

Physician CC & History of Present Illness

- Symptom/Location
- Severity
- Modifying Factors
- Context/Mechanism of injury
- Quality
- Duration
- Timing
- Associated Signs & Sx
- EMS Direction

Level 1, 2, 3 Documentation - 1 system, problem pertinent

Pain Severity 0 - 1 - 2 - 3 - 4 - 5 (Circle One)

Level 5 Documentation - 10+ systems

- All systems negative except as noted
- Unable to fully assess due to:
 - () altered LOC
 - () patient condition
 - () other

All normal

circle positive

Review of Systems

Level 1, 2, 3 Documentation - None

RISK FACTORS

Age > 35 years

CAD

HTN

DM

Family H/O CAD/MI

Menopause

Bilateral Oophorectomy

Cocaine within 1 week

Tobacco use

Level 4 Documentation - One area

Level 5 Documentation - 2 of 3 areas

ALLERGIES & MED'S

See Attached Notes.

See Attached Notes.

DM	HBP	DA	RAD
CAD	CVA	SI	
Tobacco	Marital Status		
Sub/Abuse	Lives Alone		

Review old charts

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PAGE 1

JEFFERSON HEALTH SYS. - M
COOPER GREEN HOSPITAL
EMERGENCY DEPARTMENT RECORD

HICKS, CHARLES
00-33-63-34 09102004
DOUYON, HUGUETTE
M 42 11/02/61 S

26836585

33

All elements not circled/striken/checked/annotated - were not pertinent
Level 4 - 6 to 7 body areas / organ systems

Level 5 - 8 or more organ systems
Checkmark indicates and provide additional documentation

Physical Examination

Physical Examination incomplete due to critical condition of patient.

C Vital signs per nurses notes
O Well developed, well nourished
N No acute pain/distress
S No Odor ETOH

G Alert and oriented to TPP
Y No abnormalities of mood or affect
E Memory (recent and remote) intact
B Anxious
S Depressed
T Suicidal

E PERRL
Y Conjunctiva and lids normal
E Fundi and discs normal
S EOM normal

E Otolaryngeal exam of external canal and TMs normal
N Nasal mucosa, turbinates, and septum normal
T Mouth, tongue, and pharynx normal
 Pharynx without edema, exudate, or injection

N Neck supple
E No JVD
C No thyromegaly
K No bruits

R Normal respiratory effort and excursion
E No rales, rhonchi or wheezes
S Normal to percussion
P Equal air entry

C Normal PMI with no thrills, RSR
V No murmur or gallop
C Normal carotid normal abd aorta normal femora normal pedala

(+) bilateral pedal edema & chronic venous stasis w/o edema lower legs

G Normal speech
I CN II-XII intact
G DTRs normal, no pathologic reflexes
F Normal motor and sensory function
G No ataxia
G Normal cerebellar
G Normal Romberg

G No masses, tenderness, rebound or guarding
G Normal liver, spleen, kidney
G No hernia
G Rectal, not indicated rectal normal hemoccult negative/positive
G Normal bowel sounds

G Genitalia normal to inspection
G No masses, tenderness or adenopathy
G Genitalia normal to palpation
G Normal cervix
G Normal bimanual bladder uterus adnexa CVA tenderness

Normal

No adenopathy of neck
 No adenopathy of axilla
 No adenopathy of groin
 No adenopathy, other

M Normal gait and station
 Normal digits and nails
 Muscle atrophy
 Neurovascular status intact

S Normal to inspection
 Normal to palpation

G Glasgow Coma Scale

G Initial _____ Repeat _____

Procedures

Laceration Length _____ cm, Layered Y/N

FB Y/N Neur/vas/motor intact Y/N

CRITICAL CARE TIME MUST BE DOCUMENTED

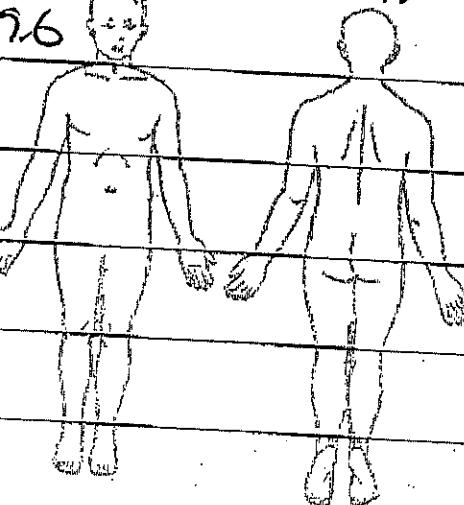
CRITICAL CARE TIME BELOW DOES NOT INCLUDE TIME FOR SEPARATELY BILLED PROCEDURES.

CRITICAL CARE Total Time _____ 30-74 minutes 75-106 minutes

Additional documentation

140 (60) 14 (13 0.2) 14.7 (29)
6.3 269 43

Ca 7.6



NAME

HICKS, CHARLES

ORDERING PHYSICIAN

PERRY, JACQUELINE T.

ATTENDING PHYSICIAN

		SEX M	ACCOUNT NUMBER 27066679
	PT. STATUS UNK	LOCATION UNK	MEDICAL RECORD NO. 00336334
	DATE OF BIRTH 11/02/1961	AGE 44	DATE OF EXAM 10/19/2004

EXAM#

TYPE/EXAM

RESULT

000451974 DXER/CHEST, TWO VIEWS, FRONT &

PA AND LATERAL CHEST: Negative study.

** REPORT SIGNATURE ON FILE 10/20/2004 **

Reported By: William P. Cason, M.D.

Signed By: Dr. William Cason

CC: PERRY, JACQUELINE T.

Technologist: JESSIE M. CALHOUN

Transcribed Date/Time: 10/19/2004 (1541)

Transcriptionist: SMOVE

Printed Date/Time: 05/19/2006 (1454)

PAGE 1

ADDENDUM Printed From PCT

RUN DATE: 05192006
RUN TIME: 1454
RUN USER: BROHECooper Green Hospital *LIVE*
Summary Discharge Report

PAGE 1

LOCATION

PATIENT: HICKS, CHARLES

ACCT #: 26836585

LOC: ER

U #: 00336334

REG DR: DOLYON, HUGUETTE

AGE/SX: 42/M

ROOM:

REG: 09102004

STATUS: DEP ER

BED:

DIS:

CHEMISTRY SECTION

Day	Date	Time	Na (136-148) MMOL/L	K (3.6-5.2) MMOL/L	Cl (98-108) MMOL/L	CO2 (21-32) MMOL/L	BUN (7-18) MG/DL
1	SEP 10	1835	140	4.3	105	25.7	14

Day	Date	Time	Gluc (70-110) MG/DL	Crea (0.6-1.3) MG/DL	ANION (9-16) MMOL/L	BUN/CREAT (12-22) RATIO	Ca (8.7-10.2) MG/DL
1	SEP 10	1835	100	1.2	13.60	16.00	9.6

Patient: HICKS, CHARLES

Age/Sex: 42/M

Acct#26836585

Unit#00336334

LOCATION

Patient: HICKS, CHARLES

#26836585

(Continued)

Complete Blood Count

Hematology Section

Day	Date	Time	WBC (4.3-10.8) TH/uL	REC (4.2-6.1) MIL/uL	HGB (13.0-18.0) g/dL	HCT (43-52) %	MCV (80-98) fL
14	SEP 10 1935		5.2	5.01	14.7	43.2	86.3
Day	Date	Time	MCH (27-32) pg	MCHC (32-37) g/dL	RDW (11.5-14.5) UNITS	PLT (140-440) TH/uL	MPV (7.4-10.4) fL
14	SEP 10 1935		29.3	34.0	14.1	298	7.5

Patient: HICKS, CHARLES

Age/Sex: 42/M

Acc#26836585

Unit#00336324

Date

10/19/04

Name

Charles E. Hucks

Primary Diagnosis

Hypertension non-compliant

Vital Signs

BP

192/110

Pulse

66

Resp

20

Temp

98

Allergies

NSA

Time Ordered

MED / FLUID / DOSE / ROUTE / RATE

① Clonidine 0.2mg po q1200

② old records

③ CXR PA + LAF RC

④ acc ✓ 110 pt B 1300

Repeat B/P 194/121 66

TED NOS knee high done

1310

1450

BP 139/92 p 65 r 18

Time Done

1310

Nurse Initials

JB

1310

1500

PTB

1600

JB

THERAPEUTIC

Consultation: Dr:

Called

Ans

Arr

Dr:

Called

Ans

Arr

Initial Impression/Different Diagnosis

HTN / Palpitations / peripheral edema

Additional history, exam, reassessments

8/5/2010
 all done

Secondary Diagnosis

Secondary Diagnosis

Secondary Diagnosis

Secondary Diagnosis

CONDITION

Stable Improved Deteriorating

Exp. AMA DC Admit IP OB Transfer to

Family Police Coroner

Time

By

DISPOSITION

Notification: Physician

Physician
 Signature
 Chart complete when checked

Ryan Polk, N.P.

NOTE
 DICTATED

CERTIFIED MEDICAL EMERGENCY

YES NO

#10113 Ryan, N.P.

EXHIBIT B

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

CHARLES HICKS (# 246241)

*

Plaintiff,

*

v.

* 2:06-CV-990-MEF

ALABAMA DEPT. OF CORRECTIONS, et al.

*

Defendants.

*

*

AFFIDAVIT OF PAUL CORBIER, M.D.

STATE OF ALABAMA

COUNTY OF Elmore

BEFORE ME, Paul Arnold Corbier, a notary public in and for said County and State, personally appeared **PAUL CORBIER, M.D.** and being duly sworn, deposed and says on oath that the averments contained in the foregoing are true to the best of her ability, information, knowledge and belief, as follows:

My name is Paul Corbier. I am over the age of twenty-one and am personally familiar with all of the facts set forth in this Affidavit. I have been licensed as a physician in Alabama since 2005, and have been board certified in internal medicine since 1998. I have served as the Medical Director for Staton Correctional Facility in Elmore, Alabama since July 2006. I also provide treatment to inmates at Frank Lee Youth Center in Deatsville, Alabama that are brought to Staton Correctional Facility. Since July 2006 my employment at Staton Correctional Facility has been with Prison Health Services, Inc. ("PHS"), the company which currently contracts with the Alabama Department of Corrections to provide medical services to inmates.

Charles Hicks (#246241) is an inmate who was incarcerated at Frank Lee Youth Center and treated at Staton Correctional Facility at all times relevant to this matter. I have reviewed Mr. Hicks' Complaint in this action as well as his medical records (certified copies of which are being produced to the Court along with this Affidavit).

It is my understanding that Mr. Hicks has made a Complaint in this matter that Frank Lee Youth Center has failed to provide him with appropriate medical treatment between April 2006 and October 19, 2006. Mr. Hick's allegations are unfounded, as this inmate has been provided appropriate care at all times.

Mr. Hicks has a medical history of Diabetes and swelling in his left leg with venous insufficiency. His Diabetes is a hereditary condition. He has circulatory problems which are complicated by problems with his feet. His condition can be treated by controlling his Diabetes and swelling in his left leg, but there is no cure. Mr. Hicks has been treated at Staton Correctional Facility for these problems with medication, blood tests, diagnostic studies and TED hose. Mr. Hicks requested diabetic shoes and his request was submitted to the proper authorities. His request was denied due to his lack of meeting the proper criteria. I have since re-evaluated Mr. Hicks and resubmitted his request based on additional information I obtained. He has been treated each time he raised any health complaints.

Based on my review of Hicks' medical records, and on my personal knowledge of the treatment provided to him, it is my opinion that all of his medical conditions and complaints have been evaluated in a timely fashion at Staton Correctional Facility, and that his diagnosed conditions have been treated in a timely and appropriate fashion. At all times, he has received appropriate medical treatment for his health conditions from me and the other PHS personnel at Staton Correctional Facility. At no time has he been denied any needed medical treatment. In

other words, it is my opinion that the appropriate standard of care has been adhered to at all times in providing medical care, evaluation, and treatment to this inmate.

At no time have I or any of the medical or nursing staff at Staton Correctional Facility denied Hicks any needed medical treatment, nor have we ever acted with deliberate indifference to any serious medical need of Hicks. At all times, Hicks' known medical complaints and conditions have been addressed as promptly as possible under the circumstances."

Further affiant sayith not.

Paul Corbier
Paul Corbier

STATE OF ALABAMA)
)
COUNTY OF _____)

Sworn to and subscribed before me on this the 12 day of
December 2006.

Annie Latimer
Notary Public

My Commission Expires:

12/06/2008

EXHIBIT C

IN THE DISTRICT COURT OF THE UNITED STATES
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

CHARLES HICKS, (AIS #246241),

*

Plaintiff,

*

v.

2:06-CV-990-MEF

*

ALABAMA DEPT. OF CORRECTIONS, et al.

*

Defendants.

*

AFFIDAVIT OF DARRYL ELLIS, DIRECTOR OF NURSING

BEFORE ME, Annie Latimore, a notary public in and for said County and State, personally appeared **DARRYL ELLIS, DIRECTOR OF NURSING**, and being duly sworn, deposed and says on oath that the averments contained in the foregoing are true to the best of her ability, information, knowledge and belief, as follows:

“My name is Darryl Ellis. I am over the age of twenty-one and am personally familiar with all of the facts set forth in this Affidavit. I have been a licensed, registered nurse in Alabama since 1995. I hold an Associates Degree in nursing from Troy State University. Since 1995, I have practiced as a registered nurse in a variety of positions and settings. In particular, I have worked at Staton Correctional Facility in Elmore, Alabama as a LPN since 1985 and as a registered nurse since 1995. Staton Correctional Facility also provides treatment to inmates at Frank Lee Youth Center in Deatsville, Alabama. Since October 2005, I have been employed as the Director of Nursing for Staton Correctional Facility by Prison Health Services, Inc., the company which currently

contracts with the Alabama Department of Corrections to provide medical services to inmates.

Prison Health Services, Inc. (PHS) has established a simple three-step procedure for identifying and addressing inmate grievances at Frank Lee Youth Center. If an inmate has a grievance regarding a healthcare issue he must submit to the healthcare unit a "Medical Complaint Form." These are standard forms that may be requested from an inmate's supervising officer in his dormitory. The inmate medical complaint form allows an inmate to communicate any healthcare related concern by placing the medical complaint form in the sick call box or mailbox to be forwarded to the healthcare unit. I subsequently review the request and respond accordingly via in-house mail. Also, when deemed necessary, the inmate will receive a face-to-face interview with me or the doctor or both. At this time, the needs of the inmate are addressed and treatment is discussed.

If an inmate is unsatisfied with my response, he may request an "Inmate Formal Grievance" form from the healthcare unit. This form allows an inmate to again voice his concerns relating to the healthcare issue addressed with the medical complaint form. I again respond to the inmate via in-house mail.

If the inmate is still unsatisfied with my response, he or she may request from the healthcare unit an "Inmate Grievance Appeal" form. This form is again submitted to me and represents the final step of the appeal process. After an inmate submits an inmate grievance appeal, I will meet with the inmate face-to-face in a final attempt to address his concerns verbally.

It is my understanding that Charles Hicks has filed suit in this matter alleging that PHS has failed to provide him with appropriate medical treatment between April 2006

and October 19, 2006. However, Mr. Hicks has failed to exhaust Frank Lee's informal grievance procedure relating to the receipt of medical care for this alleged condition. Specifically, Mr. Hicks has not submitted all appropriate and required forms. As such, the healthcare unit at Frank Lee Youth Center (Staton Correctional Facility) has not been afforded the opportunity to resolve Mr. Hick's medical complaints prior to filing suit.

Further affiant sayeth not.

Darryl Ellis, DON
DARRYL ELLIS
DIRECTOR OF NURSING

STATE OF ALABAMA)
COUNTY OF Elmore)

Sworn to and subscribed before me on this the 8th day of
January, 2007.

Annie Latrice

Notary Public

My Commission Expires:

12/06/2008

EXHIBIT D



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Charles Hicks

Date of Request: 8/2/06

ID # 246241

Date of Birth: 11-2-61 Location: 2Dorm/Bed 20

Nature of problem or request: I need to see a doctor real bad because i am not feeling well at all, as soon as possible, i am having trouble with my left shoulder, and my diabetes and blood
Charles Hicks Presu

Signature

DO NOT WRITE BELOW THIS LINE

Date: 1/1

Time: AM PM

Allergies:

RECEIVED

Date: 8/2/06

Time: 10:44pm

Receiving Nurse Initials JP

(S)ubjective:

(O)bjective

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE EMERGENCY

If Emergency was PHS supervisor notified: Yes No

Was MD/PA on call notified: Yes No

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

EXHIBIT E

Nursing Evaluation Tool:		General Sick Call
Facility:	Alabama Department of Corrections	
Patient Name:	Fricka	
Inmate Number:	246241	Last: _____ First: _____ MM DD YYYY
Date of Report:	8 123 106	Date of Birth: 11 12 16 MM DD YYYY
Time Seen: 12:30 AM / PM		Circle One

Subjective: Chief Complaint(s): Came back Monday from Court in Jefferson
Onset: County Have not had any medicine since
Brief History: Semolay. I get Diabetic medicine, Lasix, TBP
 (Continue on back if necessary)
 medicines, Aspirin. I would like my
 medications restarted.

Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98¹ P: 72 RR: 12 B/P: 147 / 86

Examination Findings: On exam calm, oriented, cooperative.
 (Continue on back if necessary)

Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):

Referral NOT REQUIRED

Referral REQUIRED due to the following: (Check all that apply)

Recurrent Complaint (More than 2 visits for the same complaint)

Other: _____

ptt note on Aug MAR to give meds from ROP
 MAR book to give stock & unit serous. (BBR)

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

Instructions to return if condition worsens.

Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits)

Other: _____

(Describe)

OTC Medications given NO YES (If Yes List): _____

Referral: NO YES (If Yes, Whom/Where): _____

Date for referral: / /

MM DD YYYY

Referral Type: Routine Urgent Emergent (if emergent who was contacted?)

Time

Chas. M. Mullins, R.N.

Name: _____

Printed: _____

EXHIBIT F

POLICY/PROCEDURE

Prison Health Services, Inc

Date of Origin: 11/03/03
 Date of Previous:
 Revised Date: 1/1/05
 Revised Date: 5/18/05

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FACILITY NAME: Alabama Department of Corrections

COUNTY:
 STATE: Alabama

TITLE: Grievance Mechanism for Health Complaints

NUMBER: GP011

REFERENCE: NCCHC : P-A-11; ACA Standard 1-HC-3A-01

POLICY:

It is the policy of PHS to encourage the resolution of inmate concerns regarding the health care system prior to the documentation of a written grievance. A grievance mechanism addresses inmate's complaints about health services.

PROCEDURE:

1. The Health Administrator will work with the facility administrator to ensure that there is a well-defined procedure for handling inmate grievances and appeals.
2. When a grievance about health care services is received (inmate grievance), the medical record is reviewed, and if necessary, the inmate is interviewed. A review of the grievance occurs within 3 days after receiving the grievance and answered.
3. Immediate resolution is expected if the grievance involves the inmate's access to health care. The Warden or Warden's designee will be copied.
4. Every effort will be made to resolve the inmate's grievance to his/her satisfaction.
5. If the grievance cannot be resolved to the inmate's satisfaction, the inmate may request an appeal in which case the written grievance will be reviewed through the facility review process and answered within 5 days.
6. Separate logs will be maintained for grievances and grievance appeals.
7. Summary review of inmate health care (grievances and grievance appeal logs) are included in the Quality Improvement meetings and identified problems are viewed as opportunities to improve care.